HOSPITALS

HOSPITAL L

A system for avoiding medical gas mixups
—Leonard P. Goudy

For successful care of premature infants
—Edwin F. Daily, M.D.

Improvements in the Master Menu service
—a new diet manual

Departmental organization of the hospital
—a special section

AUG 10 1951
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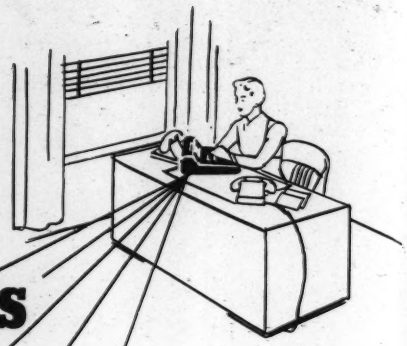
The Journal of the American Hospital Association

Eliminate late charge losses



THE problem of late charge losses has been successfully eliminated in hospitals served by TelAutograph Telescriber Systems. This method of *instant handwritten* communication assures late charge control.

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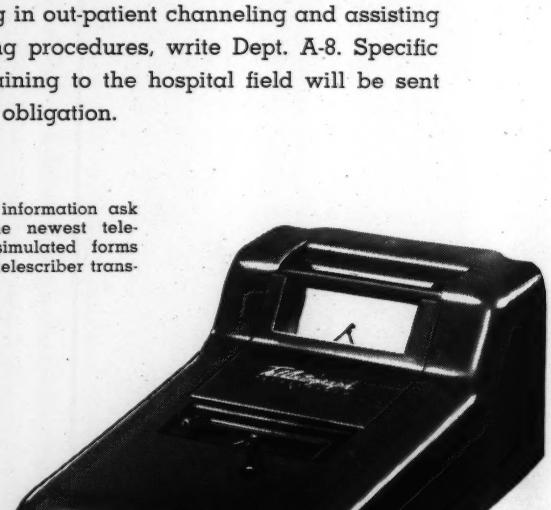
To learn more about how a TelAutograph Telescriber System can serve your hospital by controlling late charges, aiding in out-patient channeling and assisting in general filing procedures, write Dept. A-8. Specific literature pertaining to the hospital field will be sent to you without obligation.

When writing for information ask for details on the newest telescriber feature—simulated forms on your hospital's telescriber transceivers.



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CUTS WORK WEEK 8 HRS... WITH 4 LESS OPERATORS

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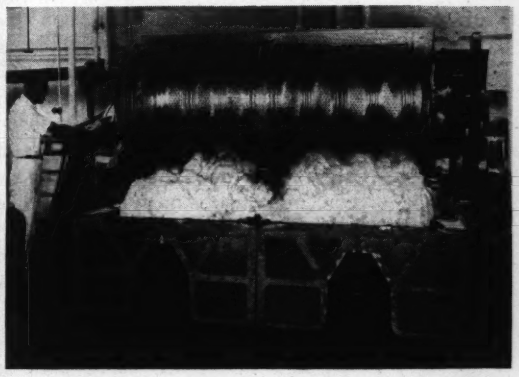


Merely pressing buttons automatically unloads washed work from CASCADE Automatic Unloading Washer into NOTRUX Extractor Containers in less than a minute, at Peralta Hospital. Automatic Control (at operator's left) takes washer through complete load cycle without attention from operator.

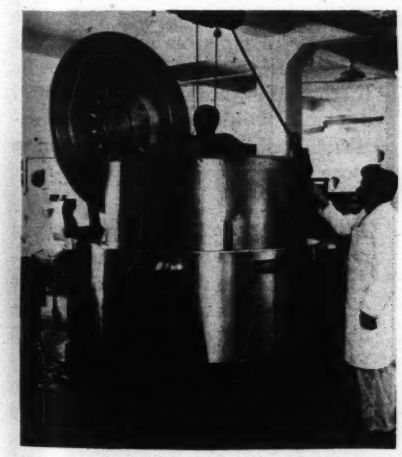
Efficiency-minded management of 150-bed Peralta Hospital modernized the laundry department with high-production, labor-saving AMERICAN equipment.

Our Laundry Advisor worked closely with Hospital officials; making a complete survey of the clean linen requirements . . . recommending new equipment necessary . . . submitting a floor plan layout of the laundry department.

Adoption of our Laundry Advisor's recommendations benefited the Hospital in the following ways: ***reduced work week 8 hours . . . 4 less operators needed . . . less floor space required . . . lowered costs . . . linens returned to service in shorter time . . . better quality work.***

The services of our Laundry Advisor are available to hospitals, large or small, ***without any cost or obligation whatever.*** He will make a survey to determine the best method of solving your particular laundry problem . . . submit a suggested floor plan layout to assure fast, economical flow of work through the laundry. WRITE TODAY . . . for our Laundry Advisor to call at your convenience.

REMEMBER . . . Every Department of Your Hospital Depends on the Laundry.



Loads are changed in NOTRUX Extractor by means of push-button operated electric hoist. Eliminates manual handling of work, saves time and labor in loading and unloading Extractor.

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TRUMATIC Folder at delivery end of SUPERSYLON Flatwork Ironer automatically quarter-folds large linens lengthwise, enabling only one receiving operator to cross-fold and stack all work.

MY ACTIVITIES on behalf of the American Hospital Association began during the early days of the month with the afforded privilege to attend and represent our membership at the annual meeting of the Catholic Hospital Association in Philadelphia, the 36th annual convention of this great organization. The opening session was presided over by the Right Reverend Monsignor John R. Mulroy, who delivered his presidential message, which was followed by an excellent keynote address presented by the Most Reverend Hugh L. Lamb. The afternoon, too, furnished the background for the presentation of a plaque to the Pennsylvania Hospital in commemoration of the 200th anniversary of the founding of this institution, which our own John Hatfield has directed so ably and well for a number of years.

MY TOPIC on the program was "The Place of the Voluntary Hospital in the Emergency." I did not limit myself to the association of the implication of an emergency to the present world situation and proposed plan to combat the hazards of atomic bombing. I preferred, instead, to approach this topic in a broader and historical sense, describing the hospital in the light of its achievements, traditions and history as an agency which has demonstrated on many occasions its ability to cope with catastrophic situations. I presented some evidence of just how the hospital has demonstrated its value not only in war but in peacetime disasters, such as floods, explosions, railroad wrecks and the Cocoanut Grove fire. These are but some of the familiar examples of demonstrated hospital values in times of great stress. My remarks furnished an opportunity to dwell on the need for greater acquaintance on the part of the public of just how essential our hospitals are as great protective agencies, not only in meeting the constant hazards of illness but as educational centers training various individuals for the purpose of being qualified to practice in their respective fields and to solve the many problems involved in unpredictable illness.

WHAT HOSPITALS have done to contribute to the furtherance of knowledge and the part they have played and are continuously playing in the research field is too little understood by the American people. If I were challenged to express the one great need and obligation of those responsible for the policies of our hospitals, it would be to further this understanding. This, I am sure, would result in great material benefit to the institution so close to our hearts.

I HAD OCCASION during the past month to deliver a graduation address to a group of more than 60 dental hygienists representing the first two-year class of the Forsyth Dental Infirmary of Boston. This is one of the leading institutions in this field, generously endowed by the Forsyth brothers, great benefactors of the city of Boston. In welcoming this group into the ranks of public health and medicine, I traced a picture of evolution in the field of public health and

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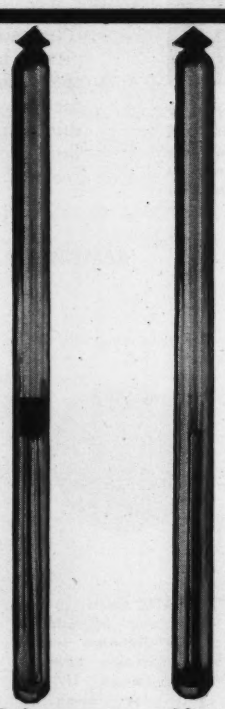

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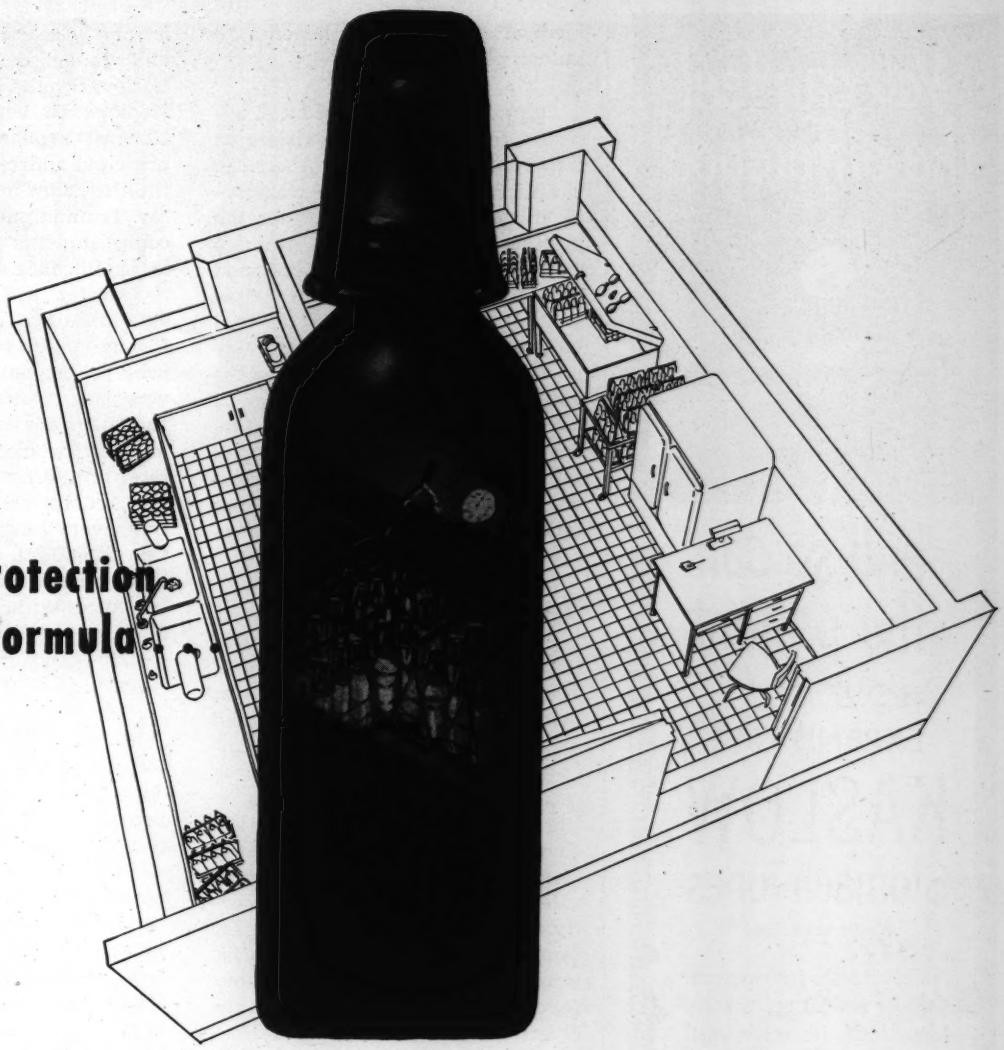

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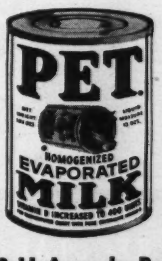

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medical care and its benefits to human progress.

DURING THE past month I had occasion to appear on television, as the representative of the American Hospital Association, and was given the opportunity to further the position of the hospitals of America and to pursue the above mentioned thoughts in an attempt to translate to the unseen audience hospital values, with emphasis on how important a part these institutions play in the life and the welfare of our people. I am happy to state that judging by the comments of some of my listeners, who passed on to me their reactions to my talks, the sentiments which I expressed were very well received.

A MOST IMPORTANT two-day meeting of the Committee on Coordination of Activities and the Board of Trustees of the Association was held in Washington. This presented an opportunity, too, for the members of the above groups to attend the cornerstone ceremony at the recently constructed Clinical Center of the National Institutes of Health of Bethesda, Md., just outside Washington, D. C. The majority of our members, I am sure, are familiar with the intimate association with this development of our fellow member Dr. Jack Masur, the chairman of our Council on Hospital Planning and Plant Operation. The Federal Security Administrator, Oscar R. Ewing, presided, and among the speakers were Dr. Detlev Bronk, president of Johns Hopkins University, and Surgeon General Leonard A. Scheele. The principal address was delivered by the President of the United States. Mr. Truman paid tribute to the accomplishments of research and to its significance as a factor in better health for the American people. The interest of the government in this field was reflected in the figures he presented pointing to the very large contributions of federal funds for the support of research and for the expansion of our hospital program under the Hill-Burton Act. He emphasized his desire that everything be done to maintain the health of the men, women and children of our country, and he expressed hope for the development of a plan acceptable to all which would make the above possible.

THE MEETINGS of the coordinating committee and the board were busy ones, including presentation of the reports of the various councils, with their recommendations. Among the varied subjects of important discussion were Blue Cross approval matters, hospital accreditation, amendments to our by-laws, decision on the Award of Merit, approval of honorary memberships, and plans for what we believe will be a great convention in St. Louis next month.

MEMBERS OF OUR Association will be delighted to be informed of the action of the House of Delegates of the American Medical Association in relation to the recommendations of the officers of their association relative to the proposed Commission for the Accreditation of Hospitals. We are to meet again for further discussion and the development of a functional organization. I am delighted to report, too, of the splendid reaction of the trustees of the American Hospital Association to my request for a conference with the committee of the American Medical Association to explore the whole question of hospital-physician relationships.

Charles F. Wilinsky

Charles F. Wilinsky, M.D., President,
American Hospital Association

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Window ventilators

What specific regulations govern the use of window ventilators in an operating room of a hospital?

Window ventilators may be used for hospital operating rooms, under the National Fire Protection Association standard, if the controls for the ventilators are outside of the hazardous atmosphere (at least five feet above the floor) and if all electrical parts of the ventilating equipment are outside the atmosphere of the operating room. They should be in part of the ventilating equipment separated from the operating room by a metallic membrane.

The 1951 edition of the National Fire Protection Association standard contains recommendations for window ventilators in Part II, Section 3, paragraph 3-2(b). The clause begins: "Window type recirculating air conditioning units may be installed in exterior windows of an anesthetizing location." Conditions for installation follow.

To get a copy of the 1951 revised edition of the N.F.P.A.'s standard, "Recommended Safe Practice for Hospital Operating Rooms," write the editorial department of HOSPITALS, 18 E. Division Street, Chicago 10.—ROY HUDENBURG.

Social security deductions

Is an administrator of a hospital considered an employee for social security purposes, and should social security deductions be made in the case of an employee who receives part of his compensation in the form of maintenance or meals?

The administrator is considered an employee in this case. An employee is eligible for social security if he makes as little as $50 in any quarter. If he earns more than $3,600, deductions are made on the first $3,600 and above that no further deductions are made until the beginning of a new calendar year, but the employee is covered for the entire period.

Maintenance must be valued and included as part of the income on which social security deductions are made. The unemployment compensation office of your state has established a set of values for meals and other maintenance which is accepted by social security officials.

When the employee is on vacation and does not receive maintenance, the tax on "fair value" of his maintenance should not be deducted. Such is also the rule in the case of an employee who receives one meal a day as part compensation. When he is on sick leave and is not receiving the meal, the value of it should not be figured as part of his income for social security tax purposes.—ALBERT V. WHITEHALL.

Classifying physicians

Into what priority does selective service classify young physicians who have had part of their medical education under the Army Specialized Training Program?

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Toxicity of refrigerants

What information can you give me on the relative toxicity of refrigerant gases?

Sulphur dioxide falls into group one, in which concentrations of ½ to 1 per cent produce death or serious injury in five minutes. Ammonia is in group two, in which concentrations of the same strength produce death or serious injury in one-half hour.

The freon gas most commonly used is freon-12, which is dichlorodifluoramethane. This is a noncombustible gas in toxicity group six. Gases in this group in concentrations as strong as 20 per cent in atmosphere produce no serious injuries after two hours of exposure. The only hazard is in the decomposition of freon gases when they come in contact with flame. The gaseous products of this decomposition have a toxicity equal to sulphur dioxide and ammonia. This is hardly a matter of concern for hospital patients since a fire hot enough to create a failure in a refrigerating system and release the refrigerant gases would be hot enough to have required the previous evacuation of the patients from the endangered area.

I believe the only precaution necessary with the use of freon gas is the installation of refrigerating equipment in areas with windows or other ventilation. This ventilation should be by a gravity vent and not ventilation dependent upon mechanical means, such as a fan and motor. Gravity ventilation tends to remove the heat generated by the operation of the equipment.—ROY HUDENBURG.

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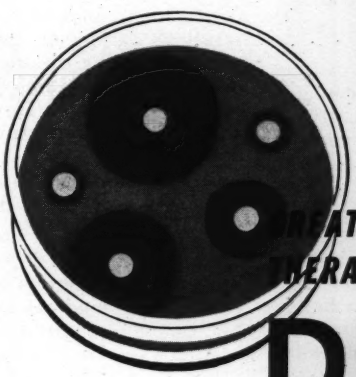
A hospital makes sure that its professional equipment is designed or installed by qualified persons. A hospital would not have its nursing procedures set up by someone who knew very little about nursing. It would be utterly foolish, therefore, to have an accounting and statistical system installed by someone knowing little of hospital accounts and statistics.

If you wanted only an audit of the hospital's accounts, any reputable, certified accounting firm probably would do as good a job as the next firm. A system installation, however, requires someone who knows the nature of the organization thoroughly. A system must fit precise facts, not an approximation of them.

Much money can be spent operating a poor, deficient or overelaborate accounting system. It is better that the hospital have a proper system installed in the first place.—WILLIAM H. MARKEY JR.

In Antibiotic Therapy



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ABOVE: Two bottom-unloading Troy 50" Olympic Extractors. Baskets lift out by electric hoist, then travel on overhead track to shake-out tables where contents are dumped.

BELOW: Two Troy 8-roll Flatwork Ironers are equipped with ventilating canopies to exhaust steam and keep operators comfortable.

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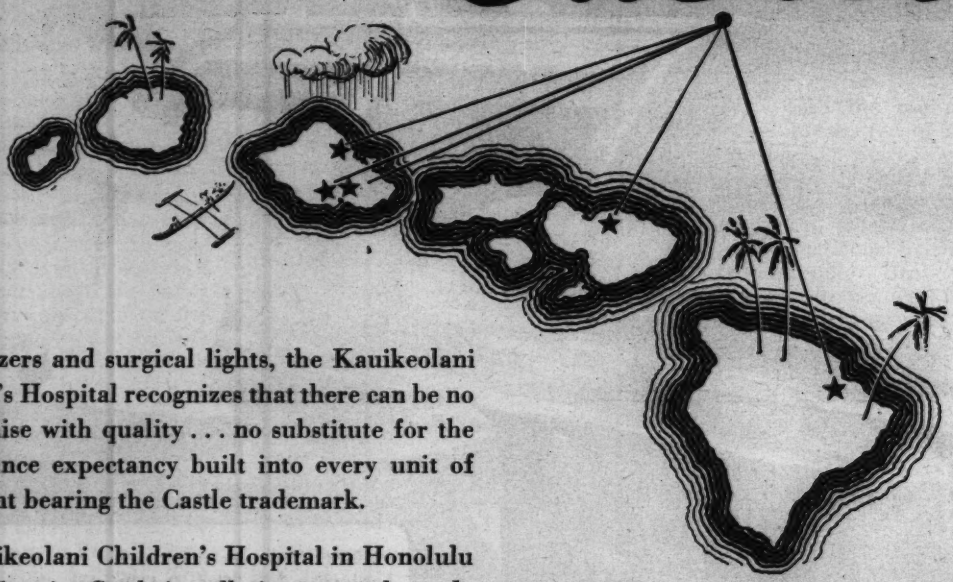

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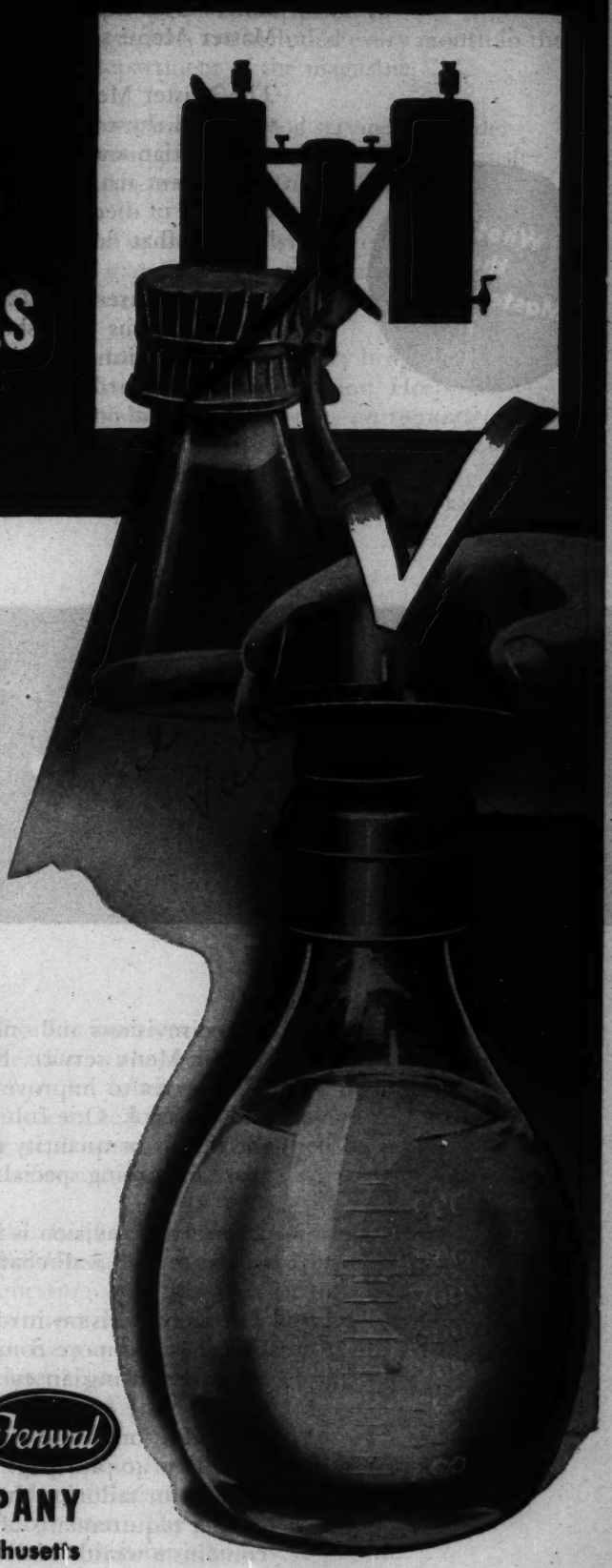

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What is the Master Menu ?

The Master Menu is a *complete* hospital food-service-planning aid. It is an expanded and improved version of the first Master Menu service introduced two years ago.

The Master Menu is designed to help *all* hospitals—those with and those without dietitians. It will save valuable time for the dietitian and thus make her a more effective department manager. Further, it provides a complete and reliable schedule of diets for every day of the month for the hospital that does not have a dietitian.

There are three essential parts: (1) A schedule of comprehensive Master Menus published each month in HOSPITALS, Journal of the American Hospital Association, (2) a set of revised Master Menu wall cards and transfer slips, and (3) a *Master Menu Diet Manual* containing brand new diet planning helps.

The Master Menu is an exclusive service that is provided for all hospitals of the country through HOSPITALS.

About the Improved

How has it been improved ?

Three revisions and one addition *improve* and *simplify* the Master Menu service. First, the wall cards have been revised. This serves to improve communications between the dietitian and the cook. One column provides space for writing in the census or quantity to prepare. The second added column provides space for noting special instructions to the cook.

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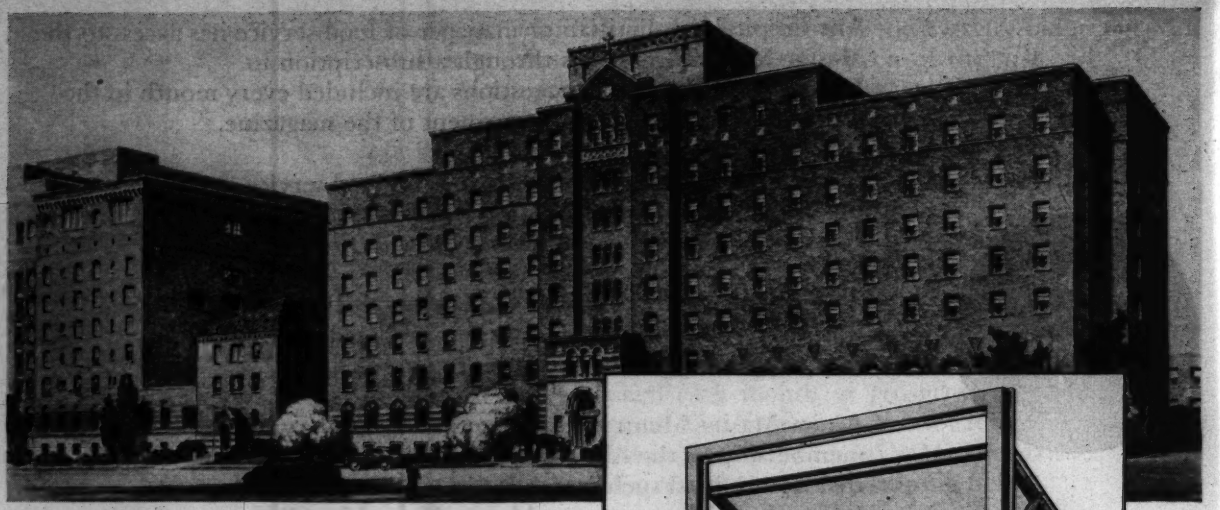
What must you do now?

If you are responsible for food service in a *hospital holding institutional membership in the American Hospital Association,* your new Master Menu kit is being mailed. No further action is necessary unless the kit should be lost *in transit.* Requests for a free replacement kit must then be postmarked no later than September 15, 1951.

If you are responsible for food service in a *hospital that does not hold institutional membership in the American Hospital Association,* address a letter requesting your new free kit to: Master Menu Department, HOSPITALS, 18 East Division Street, Chicago 10, Illinois. Requests for free Master Menu kits must be postmarked no later than September 15, 1951. After that date the price is $2 per kit.

Free distribution is limited to hospitals and to heads of departments of schools training student dietitians. The limit is one Master Menu kit to each. The cost for *additional* kits for hospitals or *initial* kits for others is $2 per kit.



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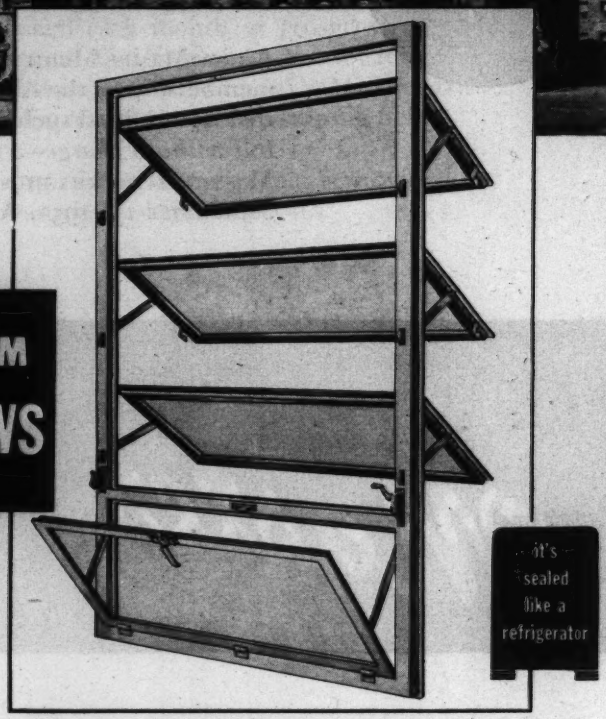

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opinions

ON STAFF GIFTS TO FUND-RAISING CAMPAIGNS

MANY hospitals today would not be existent without the public's financial support subscribed in fund-raising campaigns. Seven professional fund-raisers tell below what effect, if any, the attitude of medical staff members toward a campaign can have on its success as they give their opinions on the question: "In your wide experience in capital fund raising for hospitals, have you found success dependent upon the gifts of medical staff members, and do you believe that some approximate sum or percentage can be roughly estimated in advance as their fair share?"

Prospect needs assurance his aid is essential

THE MOST IMPORTANT factor in success is the establishment of a case which convinces the prospect that financial support is essential to health protection for the future.

A major factor in that case is the service, quality, vision and enthusiasm of the doctors. They have served in hospitals as students and interns. After being admitted to practice they use the hospitals in behalf of their patients and to their own professional benefit. Many values accrue to doctors from serving on hospital staffs. The confidence and loyalty of their patients is one value that accrues to hospitals, particularly when they must raise money.

MR. JONES

In a fund-raising campaign, doctors can be and are a distinct asset. Their assistance in giving and getting money and their promotional pleas are invaluable when fully exerted. Arbitrarily assessing these tangible and intangible values at so much per capita or group involves too much danger to the morale of the doctors, whose help must have a spontaneous quality. The help doctors can give varies in every campaign, just as does the quality and force of the leadership and workers, as well as the response of the public.—JOHN PRICE JONES, *chairman and treasurer, John Price Jones Company, Inc., New York City.*

Goal for staff averages 20 per cent of total

THE DEGREE OF success of capital fund-raising campaigns for hospitals almost invariably is in direct proportion to the interest, leadership and contributions of staff members.

If a campaign has a good cause, proper sponsorship, adequate direction and leadership, plus the enthusiastic support of a group of doctors who are giving in proportion to their means, and who are providing the interest and leadership expected of other leading citizens, it almost inevitably will succeed. You are certainly courting failure with a staff that is apathetic or fails to make contributions in keeping with its ability and responsibility.

During the depression, many doctors worked unselfishly day and night for people, many of whom would never pay. Campaign contributions from physicians during this period often were very modest; yet, because the public knew of their unselfish service, it did not expect substantial giving from staff members.

People feel that physicians and surgeons are in an income bracket high above average. They are aware, however, that any examination of the physician's charity donations reveals that he does not carry his weight in community giving.

It is common for a doctor to excuse himself on the ground that much of the work he does is unpaid. The public is aware that the volume of charity work by the physician is rapidly shrinking. It is aware also that the same charity work is used as an excuse for charging wealthier patients more than others. The public knows that membership on the staff of a hospital more than compensates for the free service. It gives the doctor prestige, the opportunity to follow his patients through hospitalized illness, and the facilities for keeping abreast of his profession.

It is not unnatural that the public, before making commitments to hospital fund-raising campaigns, ask first to see what the doctors have done.

We find that the average goal set up for staff members has been about 20 per cent of the objective. The average actual giving from staff members is about 14 per cent of the amount raised in the campaign.

The community having physicians who combine good medicine with good citizenship has little trouble with its hospital campaign. The physicians who fail to demonstrate these qualities are doing more to prejudice the public in favor of socialized medicine than can be overcome by a mere public relations campaign, and they also are threatening the success of their own local hospitals.—CHARLES A. HANEY, *Charles A. Haney and Associates, Inc., Newtonville, Mass.*

Doctors should give as much as laymen of same income

THE SUCCESS of a hospital fund-raising campaign depends greatly upon the willingness of the members of the medical staff to work for the campaign and contribute generously to it.

MR. LAWSON

The average layman takes it for granted that doctors are authorities on hospitals and are best qualified to judge the area's needs for additional hospital facilities. If the medical staff members, therefore, fail to prove the need for hospital expansion or construction by working for and contributing to the fund appeal, there is small chance of convincing the layman—particularly the man who manages industry and business—that he should support it.

What we ask in hospital campaigns is this: That a member of the medical staff give as much as a layman in a comparable income bracket and that he give before the layman is asked to give. The medical staff member has a responsibility to lead the way in giving, thus giving concrete proof of his own belief in the need for new hospital facilities.

The medical staff should accept

The artist has here depicted a brass mortar with dolphin handles, apparently made in Central Europe, by an unknown artisan, about the year 1689. It remained in Switzerland for many years and was brought to this country from there. The T-shape of the pestle handle is unusual. The original rests in the Museum of the Philadelphia College of Pharmacy and Science.

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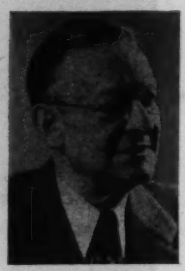
as their share an objective of from 10 to 15 per cent of the total goal of the campaign. This is a realistic figure and one which can be obtained. Since new and improved hospital facilities will provide doctors with more efficient "workshops" where they can provide more helpful care for their patients and be able to take care of more patients, they should lead the way by generous giving.

As members of a private enterprise system opposed, in general, to socialized medicine, doctors should welcome the opportunity to put their support behind voluntary hospitals. As long as voluntary hospitals continue to do their job well, the pressure for socialized hospitalization, which could be a wedge opening the way to socialized medicine, will be diminished. It is to the interest of doctors to make voluntary medicine and hospitals as fine as possible now if they are to withstand this threat.—BERNARD H. LAWSON, *president, B. H. Lawson Associates, Inc., Rockville Centre, N. Y.*

Support of staff makes success more likely

IT WOULD BE an over-simplification to say that success in hospital building fund campaigns *depends* on the subscriptions by medical staff members. Sound programs have achieved their objectives with minimum support by doctors. Our financing projects attaining the highest response, however, are those to which the medical staffs contribute generously. Strong support by the doctors at the outset unquestionably makes success more likely. For anybody other than the doctors to fix a percentage of a building fund to be met by the medical staff is an arbitrary and unsound practice. In a recent professionally directed building fund campaign, lay leaders informed the medical staff doctors that designated amounts, graduated according to the staff positions held, were expected from them. Soon afterward the state medical society adopted a resolution condemning "undue pressure and coercive methods" used to obtain contributions.



MR. SMITH

In our practice, subscriptions by members of the medical staff are sought only by a committee of doctors. No lay members of the governing board have any part in obtaining contributions from the doctors. The members of the committee, appointed by the doctors themselves, determine the amount they will seek from the staff by studying the response of doctors in a hundred or more of our recent projects. In this way they determine the "fair share" for their staff. Generally the medical staff contributes on a basis that is considered wholly creditable by the general public.—CORNELIUS M. SMITH, *president, Will, Folsom and Smith, Inc., New York and Boston.*

Doctors give large part of total in campaign

HOSPITAL FINANCING campaigns seldom meet with striking success without the wholehearted cooperation of the medical staff. In many instances, their gifts spark enthusiasm in other contributors.

MR. MACK

Doctors know more about the financial needs of hospitals than any other group and should be willing to be first in giving proportionate aid to the program. When such aid is not prompt in coming, the public is likely to become suspicious of the worthiness of the appeal and react indifferently, with resulting failure of the program.

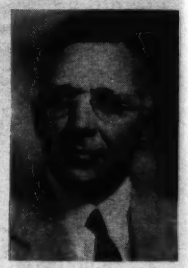
The giving of the doctor group in hospital campaigns is patterned through long and varied experience. Doctors give approximately 15 to 20 per cent of total goals. When that figure is undersubscribed, the campaign usually finds difficulty in reaching its objective.

In a recent fund-raising program, an objective of $1,700,000 was set only after it was learned that a generous donor would give an initial $1,000,000. Of the remaining $700,000, more than $200,000 was subscribed by the medical group to start the general solicitation. In Texas a few months ago, $220,000 was given by the medical group to a campaign for $1,000,000 to complete a building project, despite the fact that this group had subscribed generously only two years before to a like undertaking for the same hospital.

The doctor's dollar is highly essential to success in a hospital building campaign, and usually it can be counted on to be a substantial part of the total.—J. P. MACK, *executive director, American Bureau of Public Relations, Chicago.*

Layman depends on doctor to appraise program

MEDICAL STAFF members are a key group in hospital capital fund raising, not only as givers, but also as interpreters. Laymen depend upon their appraisal of the program and the need as authoritative and watch closely doctors' giving as a pattern for themselves and their businesses. Almost universally, success is dependent upon the quality of giving by medical staff members.



MR. BEAVER

In our last 30 capital fund programs for hospitals, 1,329 doctors—not all staff members—subscribed $1,567,909, averaging about $1,180 each. Among them, 597 doctors subscribed from $1,000 to $30,000 each, totaling $1,287,825 and averaging $2,157 each. The remaining 732 subscribed only $280,084, averaging $383 each.

The share of the total campaign goal contributed by doctors in these 30 funds is as high as 26, 22, 19 and 18 per cent, and three at 17 per cent. In two small towns it was as low as 3 and 5 per cent. Our actual median is 10 per cent of the total campaign goal from doctors.

Nothing is more obnoxious to any contributing group than an arbitrary quota lacking a sound statistical or intelligently calculated basis, and nothing is more important than the realization by contributors that amounts asked are equitable, reasonable and necessary to reach the fund goal. We set up representative estimating committees within each major contributing group, including one within the medical staff. A central estimating committee coordinates and harmonizes the estimates of all groups. Such a method of goal-setting, sagaciously and diplomatically developed, usually leads to harmonious and spirited fund raising.

The doctors, as well as the other groups, enlist soliciting units from among their own personnel. Leading medical staff members, who act as stimulating and impelling

(Continued on page 144)

Will you make this costly mistake when you build your new hospital?

IN THE INTEREST OF ECONOMY, the gentlemen above are voting *not* to install individual room temperature control in their new hospital.

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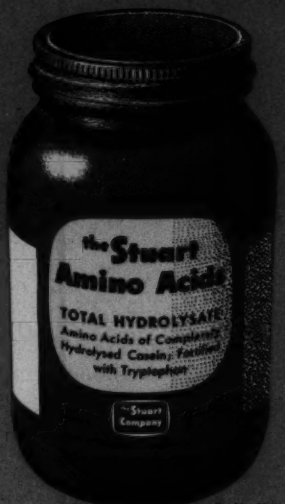

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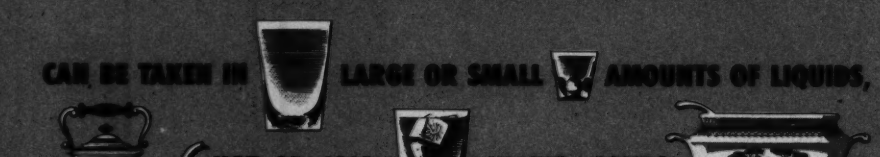

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What hospitals can do about the high PREMATURE INFANT MORTALITY RATE

EDWIN F. DAILY, M.D.

EACH YEAR in the United States there are about 200,000 premature live births. Of these, about 40,000 die within a year.

The premature infant today constitutes a major public health problem—a problem of preventing premature labor and of preventing the infant's death. The premature infant also constitutes a serious economic problem to families, to hospitals, to Blue Cross, and to other agencies buying hospital care.

Solution of these problems is partially a hospital responsibility, fulfillment of which will require concerted and coordinated effort. Only in this way can the premature death rate be reduced and the public health and economic problems that accompany premature births be alleviated.

PUBLIC HEALTH PROBLEM

A prematurely born infant by definition weighs 2,500 grams (5½ lbs.) or less. These premature babies make up 5½-7½ per cent of the *total* live births, according to several state studies of all birth certificates. They have been reported as accounting for more than 50 per cent of all infant deaths in hospitals.

It is not difficult to imagine the public indignation if that many older children died each year in American hospitals. For too long we have been undisturbed about the deaths of these tiny infants.

From the public health viewpoint, the prevention of premature labor and delivery is the most logical step, since the infant weighing *more* than 5½ pounds has 15 times the chance of a premature for surviving the first year of life. We do not know as much as we would like about preventing premature labor but we know prevention is important. Studies in England, Canada and the United States have shown a marked reduction in premature labor when the mothers' diets were adequate. Studies in Denver and Baltimore show a much higher incidence of premature labor among mothers with little or no prenatal care.

Hospitals, working closely with state and local health departments, should make certain that all mothers have an opportunity to receive *good* prenatal care. Wherever prenatal clinics are needed to provide good prenatal care, they should, if feasible, be established in the hospital where the mother will eventually be delivered, to assure continuity of care. Good prenatal care, with early hospital care available if complications such as toxemia occur, often would delay the birth of a 1,500-gram fetus until it weighed 2,000 or more grams, when its chances of survival would be far greater.

PREVENTING MORTALITY

At one well-known hospital with a premature center fully equipped and staffed to provide the most skilled care, the mortality rate for prematures born in the hospital is less than 10 per cent—one-half the national premature mortality rate in hospitals. If that low rate could be achieved by *all* hospitals, the lives of approximately 20,000 infants could be saved each year.

STUDY OF FACILITIES

One state study showed that hospitals *without* separate premature nurseries and with *no* fulltime nurses for nursery duty had premature mortality rates 50 per cent higher than that of hospitals with modern premature nurseries and specially-trained, skilled, fulltime nurses taking care of the prematures 24 hours a day.

Fathers and mothers would not be so complacent if they knew that in a few hospitals their premature infants had a 50 per cent better chance of living than in many of the other hospitals.

Some people may wonder if trying to save prematures is worth the time and effort. I say that not even the risk of an occasional blind infant can salve our conscience for the unnecessary death of any premature infant—for who are we to say *what* life may be worth saving and *what* infant holds potentialities for the world? The following were born prematurely: Sir Isaac Newton, an unusually small premature; Charles Darwin, Napoleon, Voltaire, Victor Hugo, Winston Churchill, and undoubtedly many of us.

A study at Michael Reese Hospital, Chicago, showed conclusively that at the end of five years no difference in development could be

Dr. Daily is deputy medical director, Health Insurance Plan of Greater New York. He formerly was director of the Division of Health Services, Children's Bureau, Federal Security Agency. This article was adapted from a speech given at the Midyear Conference of the American Hospital Association in February 1951.

detected between a premature and a fullterm infant, if no congenital malformation or injury was present at birth.

WHAT HOSPITALS CAN DO

Hospitals should continue and strengthen their leadership in this fight in the following ways:

1. Encourage provision of modern facilities and equipment for the care of prematures to the extent needed by each nursery service.

2. Emphasize the importance of a medical and nursing staff which has acquired the expert knowledge needed to save the lives of these infants. (At least one doctor and one nurse from every hospital should have received such training.)

3. Study the experiments of a few states and cities that have developed and staffed strategically located hospitals designated as premature centers, to which the smallest prematures born at home or in hospitals without adequate facilities and staff can be transported.

4. Secure accurate comparable data from all hospitals about the incidence and mortality of prematures. (See new "Recommendations for Developing Comparable Statistics on Prematurely Born Infants," published by the Children's Bureau and the Public Health Service.) Analyze such data, hospital by hospital, with the help of state and local health departments and medical society committees to determine the preventable factors. All facts on the incidence of prematurity and mortality should be impartially presented to the entire professional staff and the board of trustees, seeking their help in making the changes needed.

5. Achieve a cooperative plan with the local health department or visiting nurse association to safeguard the care of these infants when they go home*.

Before leaving the hospital, the mother should be taught how to care for her infant after she has returned home. There should be visits by a public health nurse to the home before the baby's discharge, and no discharge should be made if home conditions are not adequate.

6. Compare experience with other hospitals by means of hospital association studies of facilities and staffs for the care of prematures, studies of incidence and mortality, and studies of discharge policies.

7. Work closely with state maternal and child health staffs and help strengthen their work by giving them full support. Many state health departments have specially trained medical and nursing staffs to consult with hospital staffs to help evaluate their maternity and newborn services, to advise them concerning changes, and to help arrange for postgraduate courses for key staff members.

*See "A Home Follow-up Plan for Care of Premature Infants" by Karl S. Klicka, M.D., printed in the July 1951 issue of HOSPITALS.

ECONOMIC PROBLEM

The cost of hospital care of premature infants is approximately $45,000,000 per year (estimated on the basis of average stay of 20 days, times estimated average cost of $14 per day, times estimated 160,000 prematures born in hospitals). If a hospital has 1,000 total births per year, the cost of care of premature births alone in that hospital will be approximately $18,000 per year.

Studies have shown, for example, that the average cost of hospital care of a premature weighing less than 1,500 grams is $827. For a premature weighing from 1,500 to 2,000 grams, the average cost is $572, and for one weighing from 2,000 to 2,500 grams, the average cost is $199.

How many families can afford to pay the total cost of hospital care of a premature baby? Very, very few.

Only about 25 Blue Cross plans provide any coverage for a premature infant after the mother goes home, and only seven Blue Cross plans count a premature infant day of care the same as that of an adult patient.

Several state health departments have endeavored to pay for such care in centers approved as meeting all necessary standards. Approximately $1,000,000 per year of the federal maternal and child health grants-in-aid now are used for such purposes in demonstration programs only. Few state health departments have sufficient maternal and child health funds now for an extensive premature care program.

Since funds from patients, Blue Cross, or from public agencies are not covering the full cost of such care, it must be in a large part absorbed by the hospitals—perhaps it is not a small cause of deficits.

I believe that hospital associations should study thoroughly the cost of care of prematurely born infants and work out plans for covering such costs either by tax funds or insurance.

OFFICIAL CALL

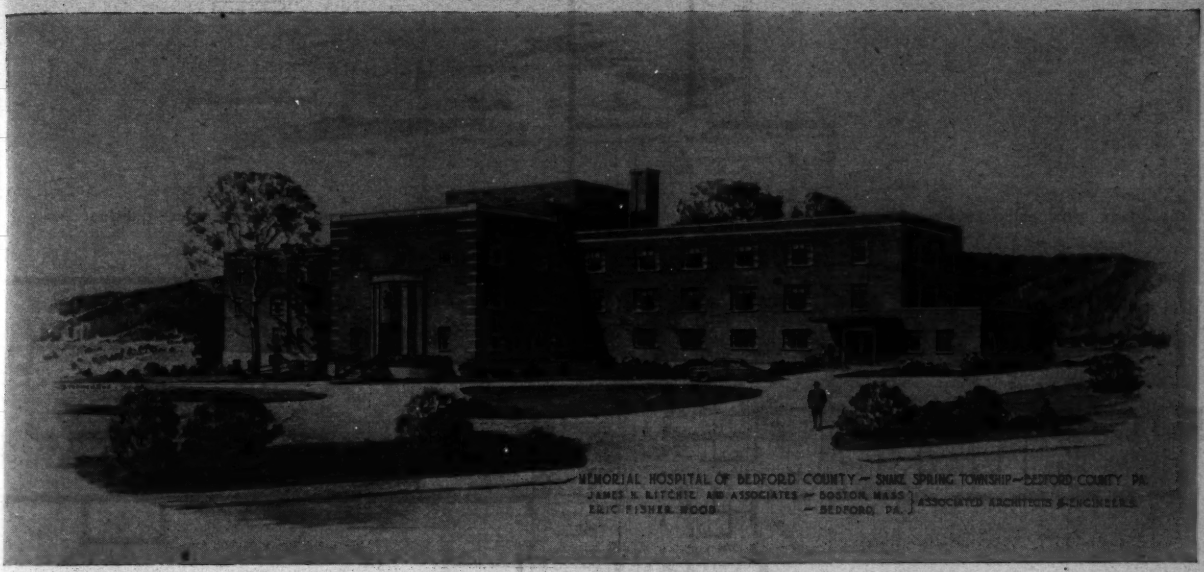
Convening the House of Delegates and Assembly

Under the authority of the By-Laws of the American Hospital Association and by direction of Charles F. Wilinsky, M.D., president, I, George Bugbee, secretary of the House of Delegates, hereby issue this, the official call to the members of the House of Delegates to convene at St. Louis, Missouri, on Sunday, September 16, at 9:30 A. M., at the Jefferson Hotel, for the transaction of the business of the Association, to receive the reports of the several councils and committees, to consider resolutions presented, for the election of officers, for the consideration of new business, and of any other matters pertaining to the Association brought to the attention of the House of Delegates by the president, the members of the Board of Trustees, or the members of the House of Delegates. The House of Delegates will recess, reconvening on Wednesday, September 19, at 8 P. M.

There will be two general sessions of the Assembly, at the Jefferson Hotel, on Sunday, September 16, at 9:30 A. M., and on Wednesday, September 19, at 8 P. M.

Accomplished at the offices of the American Hospital Association, 18 East Division Street, Chicago 10, Illinois, this nineteenth day of July, 1951.

(*Signed*) GEORGE BUGBEE
Secretary


MEMORIAL HOSPITAL OF BEDFORD COUNTY — SNAKE SPRING TOWNSHIP — BEDFORD COUNTY, PA.
JAMES H. RITCHIE AND ASSOCIATES — BOSTON, MASS.
ERIC FISHER WOOD — BEDFORD, PA.
ASSOCIATED ARCHITECTS & ENGINEERS

ELIMINATING ALL WARDS AIDED IN

Designing a hospital for flexibility

DONALD RITCHIE

THE NEW Memorial Hospital of Bedford County, Pa., was designed with three basic points in mind: (1) Flexibility, (2) efficiency and economy of construction and operation, and (3) future expansion.

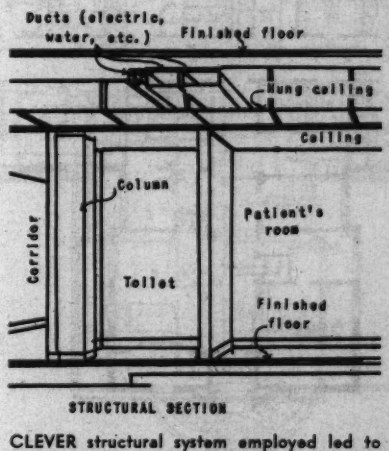
Since the hospital is near the Pennsylvania Turnpike and probably will be called upon to handle many highway accident cases, it is anticipated that the daily census will vary more than most general hospitals of comparable size.

The trustees desired to have as much flexibility as possible in the use of the available beds. This resulted in the elimination of all wards and in the designing of all rooms to adequately accommodate two beds. By so doing, the possibility of having a four-bed ward occupied solely by one female patient (for example) while there are no beds for male patients has been eliminated.

Since there are no wards, the consultants felt that the treatment rooms, nurses' rest rooms, and waiting rooms on the patients' floors could be omitted. This saving in construction costs offset the additional cost of the private and semiprivate room setup.

To develop the highest efficiency of operation possible, the general medical and surgical floor is designed as a double nursing unit having a capacity of 53 to 57 beds. The unit is served by one nurses' station, one set of utilities and one diet kitchen. Each patient room has its own toilet utility equipped with a lavatory, a water closet with bedpan-washing facilities and a cabinet work table with complete sets of utensils and supplies. This allows complete patient care without the necessity of having the nurse leave the room. It not only saves many steps but also allows each patient room to become an isolation unit on a moment's notice. Even with as large a floor as this one, the most remote bed is only 100 feet from the nurse's station and center of activity.

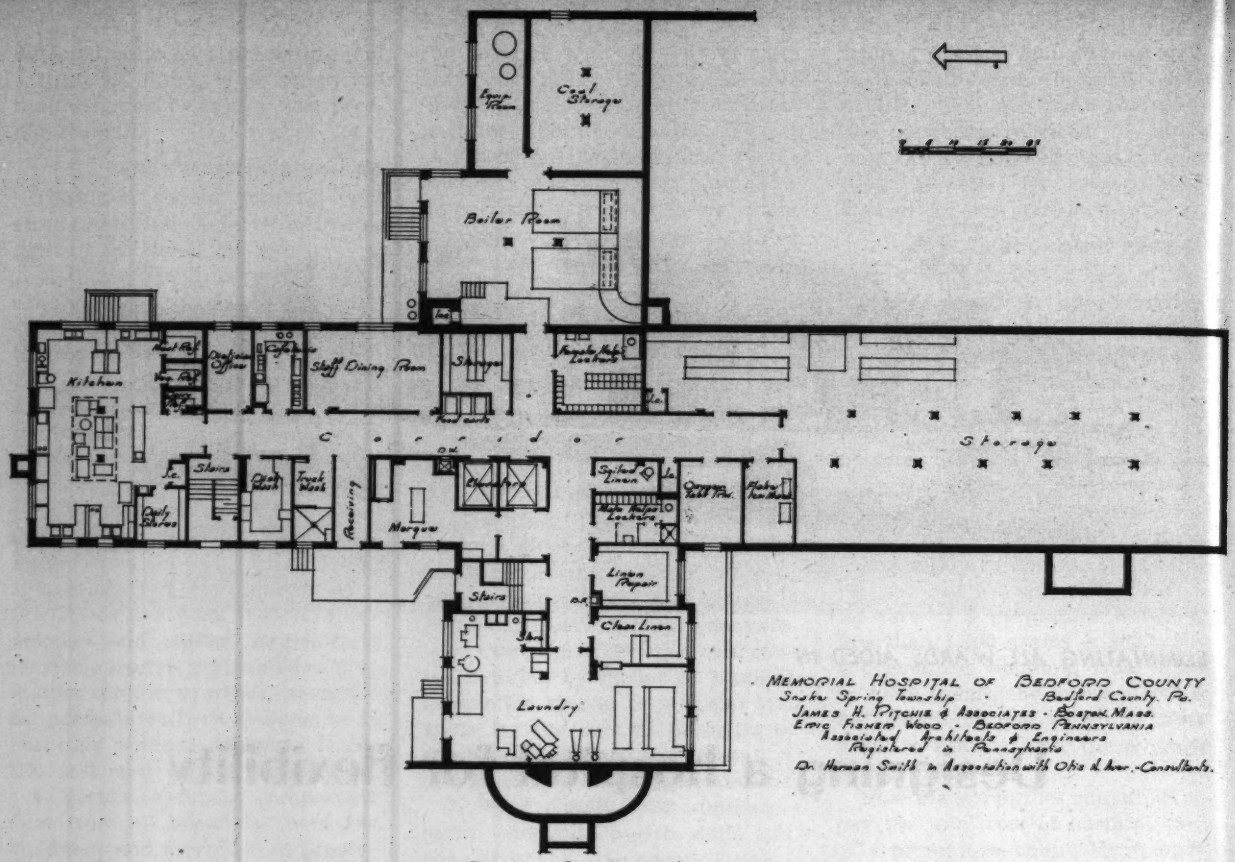
Again with efficiency and economy in mind, the first floor is designed to accommodate the operating suite, accident and emergency service, x-ray department, laboratories, and outpatient department. Thus, it is possible for an accident-emergency patient to be received, x-rayed and, if necessary, taken into the operating suite without having to undergo any vertical



STRUCTURAL SECTION

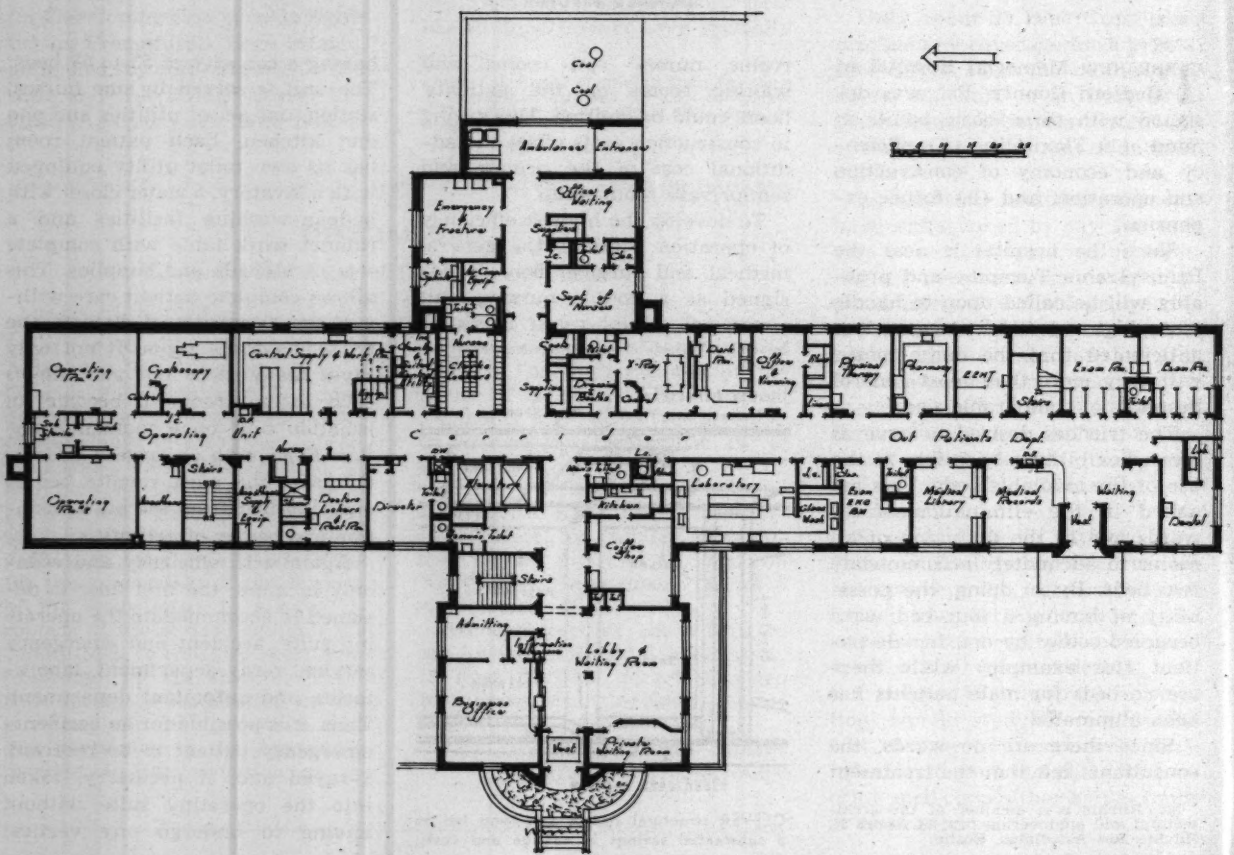
CLEVER structural system employed led to a substantial savings in cubage and costs.

Mr. Ritchie is a member of the architectural and engineering firm of James H. Ritchie and Associates, Boston.

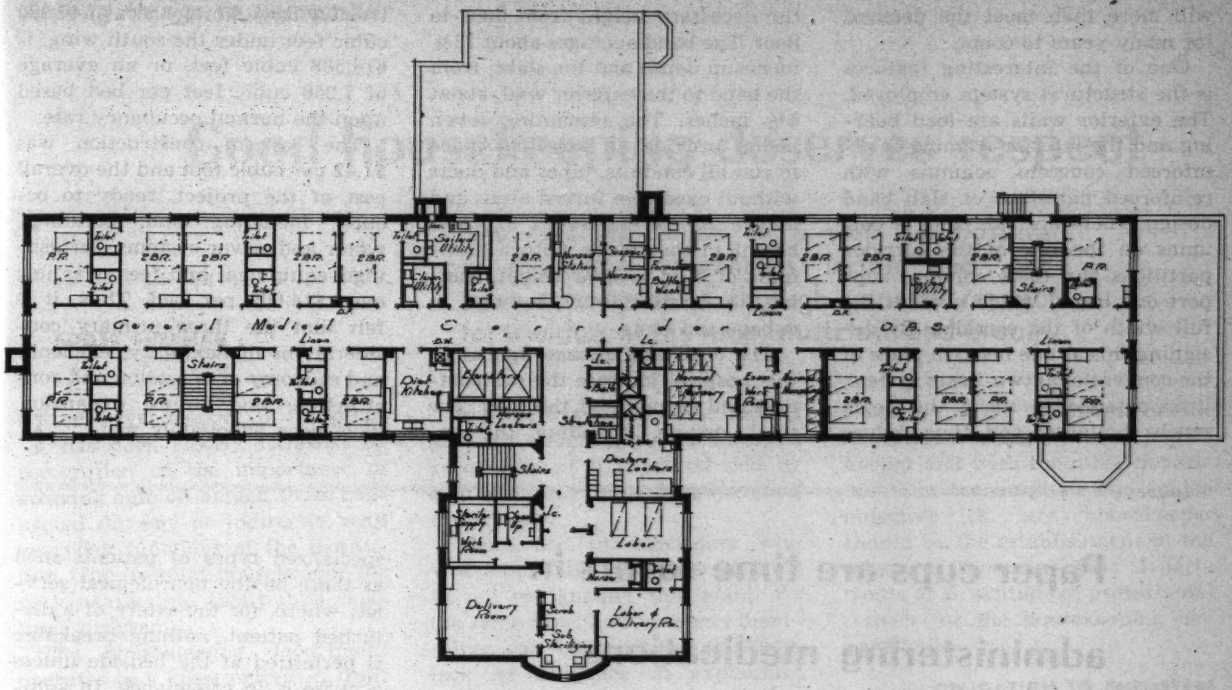


MEMORIAL HOSPITAL OF BEDFORD COUNTY
Snake Spring Township · Bedford County, Pa.
JAMES H. PITCHIE & ASSOCIATES · BOSTON, MASS.
ERIC FISHER WOOD · BEDFORD PENNSYLVANIA
Associated Architects & Engineers
Registered in Pennsylvania
Dr. Herman Smith in Association with Ohio & Iowa - Consultants

GROUND FLOOR PLAN



FIRST FLOOR PLAN

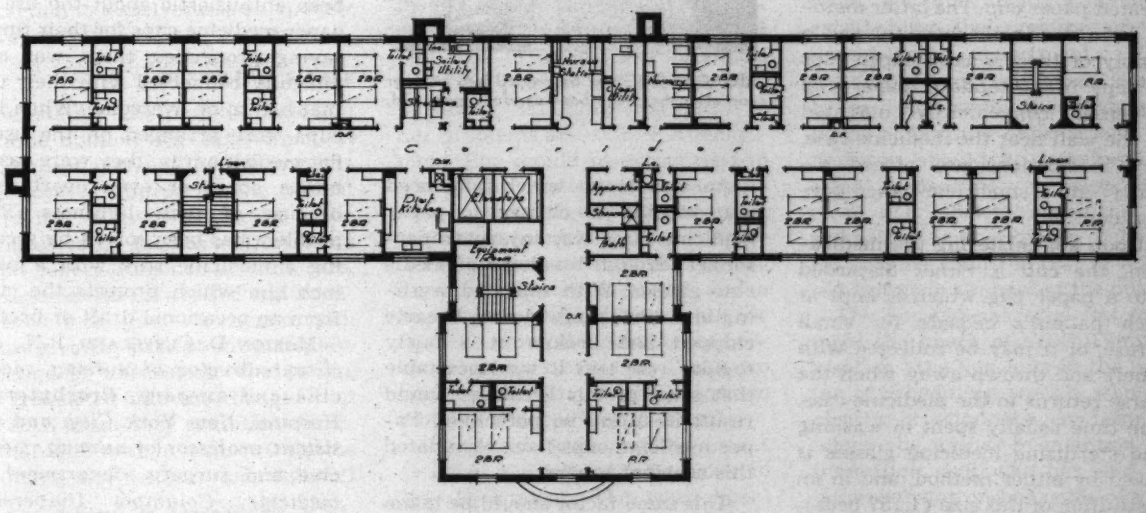


SECOND FLOOR PLAN

travel. This not only saves time in emergencies but also saves on the number of personnel needed to staff the operating suite and the emergency unit.

Another economical feature is the placement of the medical records department. By locating it adjacent to the medical library and in the outpatient area, it is possible for medical records personnel to handle all three functions of inpatient and outpatient records, medical library and the entire outpatient department.

The present hospital normally has 81 adult beds plus four pediatric cribs. This figure may be increased to 90 adult beds by converting private rooms to semiprivate and by converting the two large semiprivate rooms on the third floor to three-bed wards. If the census continues high and additions are necessary, it is planned to build two additional stories on each of the present one-story wings to the south and east. This will add 12 additional rooms, or from 12 to 24 beds. All other services in the hospital are now designed to take this additional load, and it is anticipated that the 24 added beds



THIRD FLOOR PLAN

will more than meet the demand for many years to come.

One of the interesting features is the structural system employed. The exterior walls are load bearing and the interior framing is reinforced concrete columns with reinforced flat slabs or slab band design. There are two rows of columns on the line of the corridor partitions and these columns support one beam, which extends the full width of the corridor. By designing this as one beam in place of the conventional two-beam system, it is possible to make the beam much shallower and thus reduce the necessary height from floor to floor. The band averages about 12½ inches in depth and the slabs, from the band to the exterior wall, about 5½ inches. The remaining seven inches provide an excellent place to run all conduits, pipes and ducts without excessive furred areas and allows for a maximum of clear height in the rooms, with a minimum of floor-to-floor height, leading to a substantial savings in cubage and costs.

The costs and cubage figures on this hospital indicate the compactness and economy of the plan. The total cubage, including the extremely large storage area of 44,000 cubic feet under the south wing, is 616,588 cubic feet, or an average of 7,250 cubic feet per bed based upon the normal occupancy rate.

The cost of construction was $1.42 per cubic foot and the overall cost of the project, ready to occupy, including land, buildings, water and sewer systems, furnishings, equipment and fees, was just over $14,000 per bed. Thus, it is felt that the three primary considerations of flexibility, efficiency and economy of operation and construction, and future expansion, have been adequately met.

Paper cups are time savers in administering medications

PAPER CUPS for the dispensing of both dry and liquid medications have been in use at the Presbyterian Hospital in New York City for about five years. This measure was initiated in an attempt to save nursing time formerly spent in washing and sterilizing medicine glasses for a more urgent phase of patient care.

Liquid medicines can be given in a calibrated paper cup or the medication may be measured first in a graduated glass cylinder and then poured into an unmarked and pleated paper cup. The latter method is in use in the hospital and a supply of these waxed paper cups is kept in a standard paper cup dispenser conveniently mounted on the wall near the medicine case. Dry medications are placed directly into a small one-ounce portion cup.

Upon administering the medication, the cup is either discarded into a paper bag which is kept at each patient's bedside for small refuse, or it may be collected with others and thrown away when the nurse returns to the medicine case. The time usually spent in washing and sterilizing medicine glasses is saved by either method, and in an institution of this size (1,157 beds), this has proved to be worthwhile.

MEDICATIONS may be poured into a paper cup after they have been carefully measured.

Another factor which influenced our decision to change to paper medicine cups was injury to personnel through breakage of medicine glasses. With repeated washing and sterilizing, glasses became chipped and broken at a fairly regular rate and it was inevitable that some of this breakage would result in injury to personnel. Paper medicine cups have eliminated this accident hazard.

This same factor should be taken into consideration when caring for specialized types of patients such as those on the neurological service, where, for the safety of a disturbed patient, nothing breakable is permitted at the bedside unless a nurse is in attendance. In addition to using paper medicine cups in these units, mouth care trays are set up with paper containers, and between-meal nourishments are served in paper cups.

Paper containers of all kinds are also useful in the care of another specialized group of patients—those with a communicable disease, for whom isolation technique must be observed. Food trays for these patients can be set up with attractively designed paper tray covers and the food served in paper plates and cups.

Although the nursing staff has been enthusiastic about the use of paper medicine cups for their time-saving properties, there was one difficulty connected with their use that had to be overcome. When the cups were arranged on the usual flat medicine tray, they were easily blown about or even overturned because of their lightness. This problem has been solved by securing a medicine tray with a two-inch rim which protects the cups from an occasional draft or breeze.

—MARION D. CLEVELAND, R.N., *assistant director of nursing, medicine and surgery, Presbyterian Hospital, New York City, and assistant professor of nursing, medicine and surgery, department of medicine, Columbia University, New York City.*

Good housekeeping deserves respect

The finishing touch to a well run hospital is glistening cleanliness inside and out, best accomplished through genuine respect for wielders of the mop, dustcloth and broom.

ROGER SHERMAN

THE DEVELOPMENT of hospitals has been closely followed by recognition of the importance of swaying opinion among those connected directly or indirectly with everyday functions of the institution. The hospital housekeeper fits very neatly into this public relations program.

The housekeeping department operates to a large extent in front of the public. The results of the efforts of the housekeeper and her staff are being scrutinized and evaluated constantly. Whether this is a conscious act on the part of the public is not important. Therefore, in training her people the housekeeper should never lose sight of the necessity of having her staff appear neat at all times. Their work should reflect her efforts.

If the relatives of patients are unable to see out of the windows, or if the walls are shabby, or if the maid cleaning the floor spatters the patient's dressing gown, the reaction of the public is akin to their reaction to a surly nurse or a poorly prepared meal.

HOUSEKEEPER'S TASK

Certainly in attempting to enlist public opinion, the appearance of the hospital should be the first line of positive approach. The patient and his relatives are going to be impressed by lobbies and corridors that reflect diligence in their care. Draperies that are soiled and venetian blinds that are heavy with dust give the patient an immediate feeling of uneasiness. The feeling is translated into the thought that if such unsanitary conditions exist, what then may he expect from the nursing and medical departments?

Mr. Sherman is administrator of the Children's Hospital, Akron, Ohio.

In other words, the finest nursing care will never receive its deserved recognition if it is placed side by side with an inferior housekeeping department.

There are administrators who will admit that they are at fault in not recognizing this point. At the same time, housekeepers themselves can be criticized for their lack of diligence in explaining their problems first to the administrator and then to their own people.

Housekeepers should never hesitate to bring their programs or problems to the administrator. Assurance of the department's proper place in the hospital family will make it possible for the housekeeper to instill in the workers in her department a professional pride in their accomplishments. This is the crux of adequate housekeeping in the hospital.

The department definitely will be no better than the supervisory "know how" of its head. The housekeeper should attend all department head meetings and should feel free to discuss her problems with the head of the nursing department, assuming that most of her problems are with this department. She should be encouraged to attend the various courses available in maintenance housekeeping.

Housekeepers must be a combination of a personnel man in hiring, a teacher of methods, and a buyer. One problem that faces the housekeeper is the question of personnel and personalities. These two similar sounding words refer to matters which differ greatly.

The word "personnel" is meant to cover only those who work in the department. The word "personality" edges over into the relationship of the members of the department along with the housekeeper and with the other departments in the hospital. The golden objective of any housekeeper should be the establishment in the minds of those in other departments of an attitude of professional respect for the housekeeping department.

OBLIGATION TO EMPLOYEES

We all pride ourselves on our aim of securing people of high character and ability for our working family. We must then accept the idea that all of our people are individuals who have rights and ambitions and who should be given the feeling that they are important in the general scheme of things and that the hospital depends upon their efficiency.

In connection with this, lockers should be provided for their clothing and it should be the practice, as it is at our hospital, for all employees to eat in the same dining room. We think this is valuable in establishing the prestige of the housekeeping department.

Housekeeping employees should be provided with attractive uniforms at hospital expense and the uniforms should be laundered as often as necessary to keep them clean and efficient appearing. Of course this is an expense, but it is far cheaper than the cost of a loss of prestige in the eyes of the public.

The housekeeper who has mastered the knack of skillful improvisation (the key-note in the matter of scheduling work), who has clearly in mind the condition in which she wishes to maintain her institution, and who has sold her administrator on her point of view cannot help but succeed.

The medical record—an administrative tool

ROLAND G. EATON

ALL ADMINISTRATORS are aware of the necessity for good medical records if, professionally, their hospital is to be approved and accredited and if it is to render medical care that will be recognized in the medically conscious world of today.

One may ask how the medical record department can help produce good medicine. Briefly, every administrator is responsible for making available to his medical staff and to himself the following:

1. The records of a patient's past illnesses in order that the patient may receive the proper attention without duplication.

2. A library that may be used for comparison and research.

3. Records to assist medical staff members in qualifying themselves for board membership.

These are but a few of the reasons why, from the professional point of view, a good medical record and a good medical record department are essential.

Few realize that there are probably many more ways in which the medical record may be utilized as an administrative tool. Some of the possible uses are:

1. To judge the quality of the medical staff. Our community and board hold us responsible for the quality of medicine practiced in our hospital. The following danger signs, so aptly pointed up in TRUSTEE, comprise a yardstick to measure the quality of the medical service rendered.[1]

- More than 10 per cent to 12 per cent of normal tissue removed in surgery.
- More than four per cent to five per cent caesarian sections.
- High death rate.
- More than ¼ of one per cent maternal death rate for obstetrical patients.
- More than two per cent infant mortality.
- High rate of disagreement between pre-operative and post-operative diagnoses.
- More than one per cent post-operative infections.
- Low percentage (below 15 or 20 per cent) of consultations.
- More than one per cent post-operative death rate for surgical patients.
- Post-anesthesia complications.

2. To see where we are going. In June and July of 1948, 1949, and 1950, the records of 1,000 consecutive admissions to the Rochester General Hospital were analyzed

Fig. 1—data from 1,000 admissions

The following figures show a breakdown of admissions during a three-year period. They point up the increasing number of patients being admitted who are covered by Blue Cross insurance and show the number of patients on each of the four services.

		1948		1949		1950
Pay status of patients						
Blue Cross		586		590		619
Non-insured		414		410		381
Self pay	362		318		302	
Compensation	36		47		41	
Welfare	16		45		38	
Total		1,000		1,000		1,000
Service provided						
Surgical		591		624		618
Medical		143		138		178
Obstetrical		231		197		172
Pediatrics		35		41		32
Total		1,000		1,000		1,000

Fig. 2—status of patients on each service

Over a two-year period, a greater number of patients were admitted on each of four services who held Blue Cross insurance than patients on a self pay basis.

Non-Blue Cross patients

	Private		*Semiprivate*		*Ward*		*Total*	
	1949	*1950*	*1949*	*1950*	*1949*	*1950*	*1949*	*1950*
Surgical	32	30	87	187	123	9	242	226
Medical	16	18	20	52	33	3	69	73
Obstetrical	8	6	48	56	30	6	86	68
Pediatrics	0	0	4	11	9	3	13	14
Total	56	54	159	306	195	21	410	381

Blue Cross patients

	Private		*Semiprivate*		*Ward*		*Total*	
	1949	*1950*	*1949*	*1950*	*1949*	*1950*	*1949*	*1950*
Surgical	46	64	336	328	....	....	382	392
Medical	27	33	42	72	....	....	69	105
Obstetrical	23	15	88	89	....	....	111	104
Pediatrics	4	0	24	18	....	....	28	18
Total	100	112	490	507	....	....	590	619

Mr. Eaton is business manager and assistant administrator of the Rochester (N.Y) General Hospital.

(see Fig. 1). Upon careful perusal of the chart, we detected some very obvious trends.

3. As a basis for service and economic statistics. The totals of each service including source of payment are illustrated. (Fig. 3).

4. Tallying out the hospital's bill to the patient's satisfaction. A check to see if we are billing for services rendered.

5. Cost studies to determine whether our hospital can afford to establish professional departments. The study of operative reports of 750 consecutive surgical patients' records led us to believe that a department of anesthesia would pay its way. (Fig. 4).

6. To investigate the feasibility of flat fee charges. We found it practical to make one flat drug charge for obstetrical patients rather than to make several charges for ante-partum and post-partum drugs. This resulted in savings in charge tickets and in the time of both ward clerks and accounting employees. The successful trial in obstetrics brought about a similar study of routine drugs used for all types of patients, resulting in a flat routine drug charge for them.

7. To save operating room time. Surgical staff members were always complaining that their patients had to wait days before they could be booked in the operating rooms. Operative reports were charted for a month. (Fig. 5).

8. To safeguard against malpractice suits. Good records are recognized as a legal defense.

We may well say, "But the above are not true functions of the medical record department." What more central spot for gathering hospital statistics do we have? This department has the mechanics and the mechanism—why not use it rather than set up a separate overlapping department?

These are just preliminary explorations into the uses for a medical record and a medical record department. Undoubtedly there are many other possibilities.

[1] "The Board's Control of Hospital Medical Care: Part II—Dealing with Deficiencies," TRUSTEE, the Journal for Hospital Governing Boards, December 1949. An eight-article series on this subject was reprinted as "The Board's Control of Hospital Medical Care" and is available from the American Hospital Association, 18 E. Division Street, Chicago 10. Price $1.

Fig. 3—service and department record

By using a table compiled from medical records, it is possible to obtain a complete picture of the operation of the hospital, and to note trends in operation of a service or department.

	1948	1949	1950
Inpatient hospital service			
Number of patients admitted	14,966	15,012	14,794
Number of patient days care	123,347	119,124	112,816
Average length of stay (days)	8.03	7.91	7.62
Number of births	2,520	2,612	2,209
Number of operations	6,759	6,658	6,580
Source of payment			
Blue Cross	60,568	61,545	59,799
Self pay	35,340	31,205	32,008
Compensation	6,514	4,921	4,130
Public charges	18,244	18,150	15,941
Other	2,359	3,303	928
Employee health service			
Total employee visits	5,355	7,566	9,070
Total work days lost	7,765½	6,748½	7,469¾
Outpatient hospital service			
Clinics:			
Total patients	3,839	4,114	4,198
Total visits	21,073	22,483	21,361
Medical social service			
Total patients interviewed	5,977	10,991	9,539
Professional services			
Pathology department			
Total diagnostic procedures	100,918	109,743	122,571
X-ray department			
Total diagnostic procedures	23,441	24,567	26,954
Physical medicine department			
Total diagnostic procedures	17,174	24,335	30,033
Electrocardiography and metabolism	1,893	1,944	2,304
Dietary department			
Total meals served	559,682	543,196	692,871
Nonprofessional services			
Laundry department			
Total pounds of laundry	1,192,069	1,284,667	1,307,822
Maintenance department			
Electricity: Total kilowatt hours	947,338	905,708	923,558
Steam consumption: Total pounds	46,890,220	69,807,500	44,913,100
Volunteer aide service			
Total number of hours given by volunteers	27,980	28,552	27,892

Fig. 4—anesthesia record

Records of 750 surgical patients' records indicated that a department of anesthesia would pay its own way. This chart shows anesthesia time for 750 operations (tonsils excluded) and the cost to the patient. The fee schedule used is $15 for the first half hour and $5 for each subsequent half hour.

Minutes	*Fee*	*Operations*	*Total fees*	*Per cent*
0-30	$15	285	$4,275	38.0
31-60	20	208	4,160	27.7
61-90	25	114	2,850	15.2
91-120	30	66	1,980	8.8
121-150	35	41	1,435	5.4
151-180	40	16	640	2.0
181-210	45	10	450	1.3
211-240	50	4	200	1.6
241-270	55	1	55	
271-300	60	1	60	
301-330	65	2	130	
331-360	70	1	70	
361-390	75	0	0	
391-420	80	0	0	
421-450	85	1	85	
Total		750	$16,390	100.0

Fig. 5—operating room data

Medical records proved that almost five times as many operations as were completed could have been booked. The following is the operating room data from 12 o'clock noon to 6 p.m., September 1 through September 30, 1950 (Labor Day and weekends not included).

	Orthopedic	*Other*	*Total*
Operations	19	50	69
Time	23 hrs., 20 min.	41 hrs., 10 min.	64 hrs., 30 min.
Average time for 69 operations (including 15 min. cleanup time)			71 min.
Total potential operating room time available during September afternoons			28,800 min.
Less actual operating room time used			3,870 min.
Less 15 minutes cleanup time per operation (15 x 69)			1,035 min.
Available time not used in September afternoons			23,895 min.
Potential operations not scheduled (23,895 ÷ 71)			336.

Who's who among convention celebrities

Introducing speakers and honored guests

ACTIVE MEMBERS of the hospital field and some newcomers will be in the spotlight of the American Hospital Association's 53rd convention when it meets in St. Louis September 17-20.

Traditionally, the opening convention session sets the theme for the remaining programs. Speakers at the first general session are leaders of national reputation who are qualified to speak on public health and hospital problems.

At the 1951 convention the presidents of two organizations in the medical profession will introduce the theme, "Trends influencing the quality of hospital care," and speak in particular on the subject of hospitals and the practice of medicine. Dr. John W. Cline of San Francisco, president of the American Medical Association, is presenting the viewpoint of the physician. Dr. J. P. Sanders, Shreveport, La., president of the American Academy of General Practice, will speak on hospitals and the general practitioner.

The viewpoints of the hospital trustee and the hospital administrator will be presented by Robert Cutler, president of Old Colony Trust Company, Boston, and a trustee of Peter Bent Brigham Hospital, and Association President Charles F. Wilinsky, M.D. This opening session will be on Monday afternoon, September 17, in Kiel Municipal Auditorium.

Three men well-known in hospital circles will carry on discussion of the convention theme at the second general session Tuesday afternoon. Among the major trends influencing the quality of hospital care has been the development of formal courses in hospital administration. Dr. Arthur C. Bachmeyer, director of the University of Chicago Clinics, treasurer of the American Hospital Association, and director of the administration program at the University of Chicago, may be expected to present a thorough analysis of this trend.

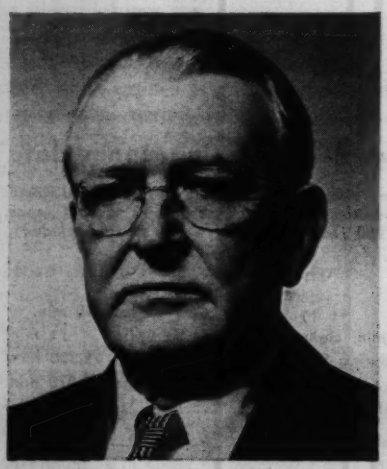
Costs and the effect of inflated costs is the subject of Dr. Albert W. Snoke's talk. Dr. Snoke is director of Grace-New Haven Community Hospital in New Haven, Conn., and chairman of the Association's Council on Prepayment Plans and Hospital Reimbursement.

Association President-elect Anthony J. J. Rourke, M.D., will discuss hospital standardization and its effect on the quality of hospital care. Much time and thought has been spent on the subject of standardization in recent years, and Dr. Rourke's talk should be both informative and useful to administrators. Dr. Rourke is physician superintendent of Stanford University Hospitals, San Francisco.

Two general sessions are scheduled for Thursday, the closing day of the convention. Speakers and their topics for the morning session —mobilization as it affects the quality of hospital care—have not yet been announced. The program for this session will be completed later in the summer to provide the most current information on the role of hospitals in national mobilization.

Thursday afternoon, at the final session of the 53rd convention, the

NOMINEES FOR HONORARY MEMBERSHIP



DR. SCHLINK

DR. SCHEELE

MR. MARTIN

topic will be "Attaining administrative flexibility in meeting changes." R. W. Bunch, division of hospital management, Public Health Service, will open the program. Mr. Bunch is chairman of the Association's Committee on Personnel Relations.

Among the speakers will be James W. Tower, New York City, discussing administrative functions, and Ray E. Brown, superintendent of University of Chicago Clinics, speaking on the organization of administrative functions in the hospital.

Closing all conventions is the annual banquet of the American Hospital Association at which new honors are conferred on outstanding members of the hospital and public health fields, and the president is inducted.

ASSOCIATION HONORS

Receiving the highest honor of the Association, the Award of Merit, this year will be Dr. Bert W. Caldwell, former executive secretary of the American Hospital Association.

Dr. Herbert H. Schlink, president of the Australian Hospital Association; the Honorable Paul Martin, Minister of National Health and Welfare in Canada, and Dr. Leonard A. Scheele, surgeon general of the United States Public Health Service have been nominated by the Board of Trustees to receive honorary memberships in the Association.

Dr. Schlink was one of the founders of the Australian Hospital Association and serves as its first president. He has aided development of prepaid hospital and medical care plans in Australia. An authority on gynecology, Dr. Schlink has combined his research and teaching activities with his interest in hospital administration.

Dr. Schlink was medical superintendent of Royal Prince Alfred Hospital, Sydney, from 1910 to 1912. Following this he joined the medical staff of the hospital and continues to take an active part in clinical work. From 1934 to the present Dr. Schlink has been chairman of the board of Royal Prince Alfred Hospital.

The Honorable Mr. Martin was born in Ottawa, Ont., and holds degrees from St. Michael's College and Osgoode Hall Law School. He was first elected to the House of Commons in the general election of 1935. Mr. Martin became Secretary of State for Canada in April 1945. His appointment as Minister of National Health and Welfare came in December 1946. In addition to his governmental activities, Mr. Martin is the honorary president of the Canadian Hospital Council.

The third nominee for membership is Dr. Leonard A. Scheele who became surgeon general of the Public Health Service in April 1948. Prior to that time, Dr. Scheele was assistant surgeon general and director of the National Cancer Institute.

Since receiving his M.D. Degree from Wayne University School of Medicine, Detroit, in 1934, Dr. Scheele has held many posts in the public health field. From 1939 to 1942 he was officer in charge of the National Cancer Control Program of the National Cancer Institute. In 1942 and 1943 he was chief of the Field Casualty Section, Medical Division, United States Office of Civilian Defense.

INFORMAL SESSIONS

Many persons known to convention-goers are scheduled for active roles during the sectional meetings on Wednesday, and other informal sessions. At the Blue Cross session on Tuesday morning, for example, the program will be under the capable leadership of William S. McNary, chairman of the Blue Cross Commission and executive vice president of Michigan Hospital Service, Detroit; Richard M. Jones, director of the Blue Cross Commission, Chicago; James E. Stuart, executive director of Hospital Care Corporation, Cincinnati, and Dr. Fred G. Carter, superintendent of St. Luke's Hospital, Cleveland.

During the convention week, administrators and others in the hospital field will meet speakers with stimulating ideas and significant comments to offer on current trends influencing the quality of hospital care. From the speakers at the first general session to the honored guests at the annual banquet, they will contribute much of value to the 1951 convention.

AWARD OF MERIT

DR. CALDWELL

Word was received July 27 of Dr. Caldwell's death at Beloit (Wis.) Memorial Hospital as HOSPITALS was going to press. A complete story will appear in the September issue.

DR. BERT WILMER CALDWELL is receiving the Award of Merit, the highest award of the American Hospital Association, in recognition of his service to the hospital field and the promotion of public health throughout the Americas and in Europe.

Dr. Caldwell was executive secretary of the American Hospital Association from 1928 to 1942. Among the services started during this period was publication of HOSPITALS magazine in 1936 with Dr. Caldwell as editor.

After graduating from Barnes Medical College, St. Louis, in 1898, Dr. Caldwell practiced medicine in St. Louis. He entered the public health field in 1905 when he was put in charge of Santo-Tomas and other hospitals in the Republic of Panama during the building of the Panama Canal.

Dr. Caldwell was a member of the Yellow Fever Commission, Rockefeller Foundation in Mexico, from 1920-22. In the following years he was superintendent of State University of Iowa Hospital and of Tampa (Fla.) Municipal Hospital, until joining the Association staff.

EDITORIALS

Better food service

IN AN ATMOSPHERE of hopeful speculation the Master Menu was first made available to all readers of HOSPITALS early in 1949. The need for some widely applicable means of improving hospital food service was obvious, but certain hazards and barriers also were obvious.

Two and a half years later the Master Menu has more than justified the sponsors' faith. In large hospitals it has been found useful as a guide to planning special diets. In smaller hospitals it has been found useful as a complete menu planning service—complete except for such minor substitutions as are indicated by local food preferences and market conditions.

As a consequence, the Master Menu kit now is being reissued with additions and improvements. Wall cards have been enlarged and their readability improved. Transfer slips have been enlarged so that the number of portions can be specified and instructions to the kitchen staff posted. A diet manual has been added. This is a guide to efficient use of the service. A total of 23 diets are discussed —the eight diets on the Master Menu plus 15 additional therapeutic diets that may be planned using the daily menus as a basis.

The new Master Menu should be an even more valuable administrative tool than the original. Because good menu planning is so essential to good patient care, this remains one of the few Association services still available to member and nonmember hospitals alike.

Administrators are urged to call it to the attention of dietitians or other supervisors of their hospital's food service. Both administrators and those who do the menu planning are invited to suggest further improvements.

Costs for emergency service

ARE VOLUNTARY HOSPITALS, in frantically trying to balance their budgets these days, unmindful of the financial losses they may be incurring in the operation of their emergency department services?

In many instances where accurate departmental cost analyses are being made in hospitals, results show that the services of the emergency department are being priced far below the actual cost to the hospital. It is granted that the first concern of a hospital in its operation of an emergency department should be the immediate rendering of surgical or medical care to the patient. But should it follow that those emergency patients who are financially able to pay for this care be billed only a nominal charge for the service?

Many hospitals are not aware of the total cost of operating their emergency service. Their accounting records reveal only certain direct expenses of the emergency department; with x-ray, central supply, pharmacy and other expenses applicable to the emergency patient lost sight of in their records. But many other hospitals do know that the emergency department is operating at a loss and still take no steps to increase their charges to approximate the cost of the services furnished these ambulatory patients. It may be that such hospitals are confusing "emergency" with "indigency" or are unaware of the fact that a large percentage of the population today carries hospitalization or accident insurance which provides hospital emergency service coverage.

Some hospital administrators believe that keeping these charges low is good public relations. Other administrators, however, have adopted what they are convinced is a more realistic attitude: The closer relating of emergency fees and charges (for both routine services of the department and all extras) to hospital costs. These administrators report this action has had no ill effects whatever on hospital public relations.

Is not a closer look at costs and charges of this department indicated?

The no-strike pledge

IN MID-JULY newspapers across the country carried their own versions of this headline: "AFL Strikers Peril Patients in 10 Hospitals." Under the headline were such items as these:

"Deliveries of milk, meat, fresh vegetables, bread and other foods were halted by sympathizing members of the AFL teamsters union . . . minor surgery was postponed in some hospitals to lighten the work of reduced service staffs and to save their resources for major operations and emergency care of the sick . . . pickets blocked doors and gates of hospital property at several institutions . . . pickets at one hospital seized the administrator and pulled his suit coat half off."

Such was the news from Minneapolis where several hospitals have been unionized for a number of years and where the original contracts were signed with a solemn pledge that there would be no strikes.

The moral here is that any no-strike pledge by a union is meaningless, even when it is made in good faith.

How a national health program can be put across

PRESIDENT TRUMAN AND Federal Security Administrator Oscar R. Ewing have invited the opponents of compulsory health insurance to a peace conference.

In his June 22 address at Bethesda, Md., the President referred to his administration's compulsory health insurance program, and then added:

> I want to make it clear, however, that I am not clinging to any particular plan. . . And I will say here and now that if the people who have been blocking health insurance for five years will come up with a better proposal—or even one that is almost as good—I'll go along with them. I want to get the job done, and I am not concerned in the slightest with pride of authorship.

Three days later Mr. Ewing presented to a press conference the outline of a new program which he calls "Old-age and survivors hospitalization insurance." As reported in the news section of this magazine, his is a plan which would use social security funds to finance 60 days of hospitalization for all people entitled to old-age and survivors insurance benefits—and in two years these people would number about 7,000,000.

When asked for comment, a spokesman for the American Medical Association promptly rejected the proposal, saying: "A better program already is available and is functioning admirably—the American medical system, which has made this the healthiest great nation in the world."

The American Hospital Association has made no official comment. Mr. Ewing's plan has been reviewed quickly by the Council on Government Relations, the Committee on Coordination of Activities and the Board of Trustees, and it has been returned to the Council on Government Relations for further study and report.

Mr. Ewing appears to have gone as far as his convictions permit in placating the opponents of compulsory health insurance.

For those who worry about a higher tax burden, he offers assurance that no new taxes will be necessary. For those who shrink from the prospects of excessive red tape and other evils of centralization, he offers to turn the distribution of funds over to state governments. For hospitals now straining to avoid operating deficits, he offers to pay actual operating costs, and he would not be fussy about the methods of calculating such costs. He would guarantee to the participating hospital "freedom from supervision or control over details of its administration, operation and personnel." Finally he would quiet the fears of physicians by eliminating them from the program; that is, by insuring the 7,000,000 against only the costs of *hospital* care.

While these are large concessions, Mr. Ewing's plan will be widely recognized as a small but almost complete package of what its proponents call national health insurance and its opponents call socialized medicine. Beneficiaries are fewer and benefits are limited, but the fearsome mechanism is intact; and this mechanism is the offer of tax-paid (hence seemingly free) service to the rich and poor, the solvent and insolvent, without discrimination. The arguments against compulsory health insurance take many forms, but all revolve around this question: Should the government try to shower its largess on everybody, or only on the estimated 15 to 20 per cent who really need it?

Would government-financed health insurance be administratively impossible? Probably not, if it covered only the 20 per cent. Would it undermine the voluntary hospital system? Would it make good medical care impossible? Would it be too expensive? Would it destroy private initiative? Would it lead to the socialization of all American life? Probably not, if it covered only the 20 per cent.

Mr. Truman and his advisers might be surprised by the ease with which they could get the job done, if they were to make a fresh start.

Suppose they were to recognize as the successful opponents of compulsory health insurance, not a handful of fiendish self-seekers but millions of citizens in all walks of life who have deep and honest fears of the consequences.

Suppose they were willing to have the government help only those who need help, letting those who are capable of doing so buy their own health insurance.

Suppose they were to nail this principle into Mr. Ewing's new plan. Who could then argue against a national health program, and what could they say?

A large state-owned mental hospital, finding that its manual accounting system was a tedious, sketchy procedure, decided to put in a machine accounting set-up. This innovation, together with a personally designed set of forms, provided savings in time and temper.

Business machine accounting in a state mental hospital

CARL D. RINKER

IN STATE OWNED mental hospitals, innovations are few and far between. The institution proceeds according to the "tradition". At the Independence (Ia.) State Hospital we have worked out some procedures in the hope that we can clear up some of the discrepancies, especially those caused by outdated manual accounting systems. For example, here is the way our system worked before we put in a highly efficient machine accounting setup.

Vouchers were classified according to the nature of the expenditure, such as salaries, provisions, repair of buildings, cleaning supplies, institutional furnishings—26 classifications in all. Each month a report of the total of each expenditure classification was prepared for presentation to the board of control. The total of 12 such reports represented the annual report.

Payroll preparation was even more laborious and produced equally sketchy records. The payroll was prepared by making a copy of the previous one, adding new employees, dropping those who had left, and recording in a hit or miss method transfers and changes of job title.

All checks were hand-written and individual employee earnings records hand-posted after the checks were distributed. (There was no personnel office nor employment clerk). Four to five days of frenzied activity were always necessary in preparation of each payroll.

Action by a forward thinking board of control resulted in approval for the purchase of a bookkeeping and accounting machine. A survey of the various makes and models of such machines narrowed the field to two, both of which featured adding machine and typewriter keyboards.

A demonstration of each machine was conducted in the company salesrooms. It had been so arranged that those employees who would be working with the machine were present at both demonstrations. The final choice was made after a thorough discussion of relative merits and represented the combined thinking of all who would be concerned.

NEW FORMS

It now became necessary to design accounting forms which would satisfactorily receive our machine-made statistics. We began with the payroll procedure. We tried to simplify as much as possible, and were able to eliminate need for a "dummy" payroll through expansion of an idea employed in the design of the employee's earnings record card. This card was so printed that the top two inches were devoted to a record of all data pertinent to the pay of the employee, including name, payroll number, job title, base rate, extras, and all regular deductions—for a full pay period.

In preparing the payroll, three copies of the payroll form with necessary carbons are first placed in the machine and aligned. The individual employee earnings record card is then inserted and a payroll check, with spot carbon in the detail stub, placed in front of it. The machine is now ready to simultaneously produce the check, record earnings and deductions on the earnings card and record all detail on the three copies of the payroll. At this point the design of our earnings card becomes valuable as it permits the machine

4-51	130.00	29.00	6.64	18.40	3.35	37.50	2.00	
	BASE PAY	MAINT-ENANCE	I.O.A.S.I.	W. H. TAX	BLUE CROSS	BONDS	GARAGE	

NAME JOHN DOE W. TAX CODE 1

ADDRESS Independence, Iowa

S. S. No. 000 00 000

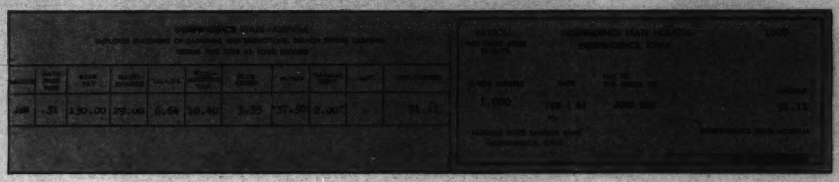
EMPLOYED Jan. 1, 1951 Attendant I

INDIVIDUAL PAY ROLL RECORD FOR YEAR 1951

MO.	DAYS PAID FOR	BASE PAY	MAIN-TENANCE	I.O.A.S.I.	WITH-HOLDING TAX	BLUE CROSS	BONDS	GARAGE RENT.	MISC.
JAN	.31	130.00	29.00	6.64	18.40	3.35	37.50	2.00	
1ST. QTR.									

THE EMPLOYEE'S earning card was so designed that the top two inches were devoted to a record of all the data pertinent to the pay of the employee for his full pay period.

Mr. Rinker is business administrator of the Independence (Ia.) State Hospital..



PAYROLL checks (left) are the size of dollar bills and have spot carbons in the detail strip. All data shown on the check is reproduced (below) on the payroll summary in one machine operation.

INDEPENDENCE STATE HOSPITAL
INDEPENDENCE, IOWA
PAY ROLL SUMMARY AND PAY ROLL CHECK REGISTER

I, ... of Independence State Hospital hereby certify, that this payroll for the month of ..... 195.... represents the amount actually due each officer and employee listed thereon according to the record of said institution. This payroll has been checked and found correct ..... Total Pay Roll $ .....
(Business Administrator)

ITEM NUMBER	MONTH	DAYS PAID FOR	BASE PAY	MAINTENANCE	I.O.A.S.I.	WITH. HOLDING TAX	BLUE CROSS	BONDS	GARAGE RENT	MISC.	NET EARNED	CHECK NUMBER	DATE	NAME	AMOUNT	REFERENCE
.00			NURSING AND CARE													
.00					.00	.00	.00	.00	.00	.00	.00				.00	
4.51	JAN	.31	130.00	29.00	6.64	18.40	3.35	37.50	2.00	.00	91.11	1,000	FEB 1 51	JOHN DOE	91.11	
			159.00		6.64	18.40	3.35	37.50	2.00	.00					91.11	

operator to read and reproduce the data visible on the top section.

It is evident that such a system could only apply in the case of employees who were never absent, who never earned overtime, and whose deduction status was constant. A study of past payrolls revealed that 65 to 75 per cent of our employees regularly fell into this category. We then worked out an "exception slip" which has successfully covered all irregularities. Roughly, this is a small paper form which can be fitted exactly over the top of the earnings record card. It is printed identical to the card top and perfectly matched with it. We have the slips in both white and pink, each for a particular use.

At the end of the pay period the time sheets are passed by the department heads to the personnel office for pre-audit. Here an "exception slip" is prepared to show all fixed data for each employee who has other than an exact full amount of time for the period or who has made a change in extra earnings or deductions.

The slips are completed in the accounting department and attached firmly to the top of the applicable card. In the case of a salary advance during the period, a pink slip is prepared in full with the advance shown as a miscellaneous deduction. With all slips in place, a reproduction by the machine operator of what she sees produces a perfectly prepared payroll, payroll checks and earning record cards posted to date.

The payroll is written by departments. Each section is totaled separately and proved against an adding machine type of gross earnings as taken from the earnings cards and exception slips.

The entire payroll procedure, including pre-audit, now takes less than two days. An up-to-date printed check with a stub containing all pay data as a permanent record is issued to employees. Errors have been cut to a minimum and individual earnings records are always posted up to date. Payroll preparation no longer creates a work load peak in the accounting offices.

BUDGETARY ACCOUNTING

We next turned to budgetary accounting. In recognition of the fact that our funds are rigidly fixed by appropriation, it was decided to organize on an encumbrance basis which would disclose at all times not only the extent of spending but also the extent to which our remaining funds had been obligated through orders and contracts placed but not yet filled or completed.

Our accounts were set up departmentally and an account classification devised somewhat as follows:

1. Administration

Salaries, Wages, Fees:

111. Regularly employed

112. Outside—other than payroll

Supplies:

121. Postage

122. General office supplies

Repairs:

131. Minor

132. Major

141. New equipment and furnishings

(This classification was followed through all departments.)

Ledger cards and budgetary report forms were simply designed, showing the budget for the department, expenditures, unexpended balance, encumbrances, and unencumbered balance. Even though our institutional funds are made available every three months in quarterly amounts, the departmental budgets were established on a yearly basis. With no historical budgetary data for reference, it was necessary to determine budgetary limits arbitrarily. In recognition of this, a reserve account was established from which later deficiencies might be eliminated.

RESULTS OF CHANGEOVER

Budgetary accounting by departments is providing a comprehensive and useful administrative tool. Inefficiency in departmental supervision is soon detected. Good departmental management is by contrast the more outstanding. In situations where the total of funds available is limited by law, encumbrance accounting provides a safeguard against deficit spending.

We have eliminated approximately 40 man hours of work each month on payroll preparation alone. (There would be correspondingly greater savings in instances where employees were paid bi-monthly or weekly.) Our

INDEPENDENCE STATE HOSPITAL
INDEPENDENCE, IOWA
APPROPRIATION REGISTER

PREVIOUS BALANCES: UNLIQUIDATED ENCUMBRANCES	PREVIOUS BALANCES: EXPENDITURES	PREVIOUS BALANCES: BUDGET	PREVIOUS BALANCES: UNENCUMBERED BALANCE	ACCOUNT NUMBER	DATE	TRANSACTIONS: BUDGET ITEMS DESCRIPTION	REFERENCE NUMBER: Encumbrance	REFERENCE NUMBER: Voucher	TRANSACTIONS: ENCUMBRANCES	TRANSACTIONS: EXPENDITURES	TRANSACTIONS: CODE	BALANCES AND TOTALS TO DATE: UNLIQUIDATED ENCUMBRANCES	BALANCES AND TOTALS TO DATE: TOTAL EXPENDITURES	BALANCES AND TOTALS TO DATE: BUDGET	BALANCES AND TOTALS TO DATE: UNENCUMBERED BALANCE
.00	.00	.00	.00	.00	JUL 10 51	XYZ COAL CONTRACT	1		10,500.00			10,500.00	.00	94,000.00	83,500.00
0,500.00		94,000.00	83,500.00	821.10	JUL 10 51				3,000.00	3,000.00		7,500.00	3,000.00	94,000.00	83,500.00
			10,500.00	821.10	JUL 26 51	XYZ COAL	1	284	3,000.00	13,500.00					

AT THE Independence State Hospital, funds are rigidly fixed by appropriation, so it was decided to organize on an encumbrance basis. The appropriation register showing encumbrance and expenditure detail is an example of the simply designed forms which are in use.

ESTIMATED AVAILABLE BUDGET BALANCES			
JUL.	94000	JAN.	55000
AUG.	90500	FEB.	42000
SEPT.	87000	MAR.	29000
OCT.	83000	APR.	17000
NOV.	78000	MAY	9000
DEC.	68000	JUNE	4000

APPROPRIATION LEDGER

ACCOUNT: FUEL — ACCOUNT NO. 821-10
ACTIVITY: Heat, Light & Power (Including coal) — PAGE NO. 1
DEPARTMENT: PLANT OPERATION

DATE 1951	TRANSACTIONS: BUDGET ITEMS DESCRIPTION	REFERENCE NUMBER: Encumbrance	REFERENCE NUMBER: Voucher	ENCUMBRANCES	EXPENDITURES	Code	BALANCES AND TOTALS TO DATE: OUTSTANDING ENCUMBRANCES	TOTAL EXPENDITURES	BUDGET	UNENCUMBERED BALANCE
	BUDGET								94,000.00	94,000.00
JUL 10 51	XYZ COAL CONTRACT	1		10,500.00			10,500.00	.00	94,000.00	83,500.00
JUL 26 51	XYZ COAL CO	1	284	3,000.00	3,000.00		7,500.00	3,000.00	94,000.00	83,500.00

ALL ACCOUNTS are set up departmentally. The budgetary breakdown is on a reducing basis for rapid visual comparison with actual operations. Segregation of operating costs by departments makes it possible to see just where and how any economies may be effected.

REPORT OF EXPENDITURES, ENCUMBRANCES AND APPROPRIATION BALANCES
INDEPENDENCE STATE HOSPITAL
INDEPENDENCE, IOWA
July 1, 1950 to June 30, 1951

DATE January 1, 1951 — DEPARTMENT _____

ACCOUNT NUMBER	ACCOUNT NAME	BUDGET	TOTAL EXPENDITURES	UNEXPENDED BALANCE	✓	UNLIQUIDATED ENCUMBRANCES	UNENCUMBERED BALANCE		
	RECAPITULATION								
.00	JAN 5 51	.00	.00	.00		.00	.00		
	RESERVE	10,000.00	-	10,000.00		-	10,000.00		
100	ADMINISTRATION	60,000.00	28,000.00-	32,000.00		12,000.00-	20,000.00		
200	LIBRARY, AMUSEMENT	6,000.00	2,500.00-	3,500.00		200.00-	3,300.00		
300	PROFESSIONAL	84,000.00	41,000.00-	43,000.00		16,000.00-	27,000.00		
400	NURSING AND CARE	300,000.00	143,000.00-	157,000.00		27,000.00-	130,000.00		
500	DIETARY	200,000.00	103,000.00-	97,000.00		37,000.00-	60,000.00		
600	HOUSEKEEPING	60,000.00	29,000.00-	31,000.00		6,000.00-	25,000.00		

THIS FORM showing the departmental expenditures and encumbrances provides an excellent administrative tool. Any inefficiencies in departmental supervision can be detected quickly, while the well managed department shows up, by contrast, as the more outstanding.

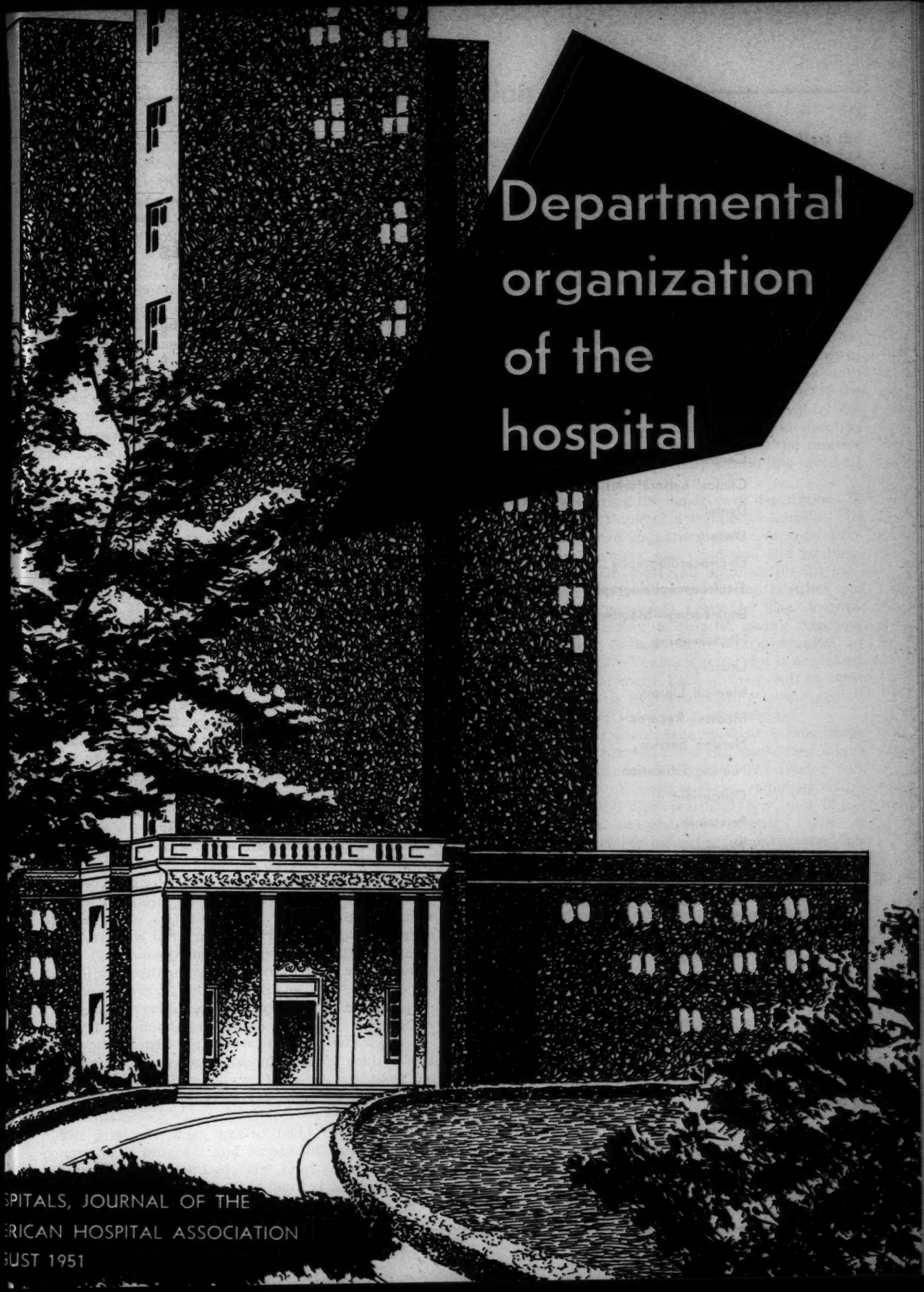
work on budgetary reporting has been equally lessened.

The greatest recommendation for machine accounting perhaps lies in the fact that (1) payroll preparation is productive of completely adequate permanent records with a minimum of effort, and (2) simple segregation of operating costs by department makes it possible to see just where and how economies may be effected without lowering standards of patient care and which economies may free some funds for increased patient care.

There is, without doubt, a place and need in state mental hospitals for machine accounting.

SPITA
ERICA
GUST

Departmental organization of the hospital



SPITALS, JOURNAL OF THE
ERICAN HOSPITAL ASSOCIATION
GUST 1951

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Introduction

THE FOLLOWING material is a preprint of the department descriptions that will be published as part of a text titled "Organizational Analysis and Job Descriptions of the Hospital and Related Health Fields." This text has been prepared jointly by the United States Employment Service and the American Hospital Association. The complete volume is being published by the superintendent of documents, U. S. Government Printing Office, and will be available to hospitals and related health groups. Announcement of publication date will be made in the near future by the American Hospital Association.

The American Hospital Association is preprinting the following departmental descriptions and organization charts because it is felt that the material will be of interest and assistance to hospital administrators, department heads and related health organizations. It is also hoped that this part of the text will stimulate an interest in and use of the total volume, which will be much more comprehensive in character.

The foreword to the full document states: "This volume has been developed by the United States Employment Service and the American Hospital Association to fill a recognized need for basic job information pertaining to hospitals and related health services occupations. The solution of problems relating to selection and referral activities in local employment services, and to placement, training and organization in institutions concerned with care of the sick and injured, has long been handicapped by the unavailability of such basic data. This situation is particularly intensified in the modern hospital, where a significant emphasis is placed on the employment of a variety of highly specialized personnel in order to meet the requirements for ever-increasing quality of patient care."

The joint project was designed to develop an occupational pattern which would permit a clearer understanding of organizational structures and job duties and fill the need for basic job information. Therefore, the descriptions of the various hospital departments include the objectives and purposes of departments and serve to establish their internal organization structures as well as their interrelationship with other departments in the institution. The departmental descriptions establish the frame of reference for the individual job descriptions.

Those who prepared this document believe it to be the first attempt to publish an expository description of hospital departments. Because hospitals differ according to size, type, location, type of control and many other variables, no two hospitals will have the same internal structure or the same number of departments.

The first task, then, was to define the hospital—a composite of purposes and responsibilities for which hospitals were organized. The brief expository description of "The Hospital" is the first section in this document. Understandably all hospitals do not perform, or offer facilities and personnel for, all of the four functions outlined in this statement. All hospitals *do* provide facilities and qualified personnel necessary for the care of the patient. In visualizing the composite hospital, the reader must recognize that functions, responsibilities, interrelationships and staffing patterns will be enumerated which do not apply to all hospitals.

The description of a department defines the functions and purposes of that department and establishes its limits of responsibility. In this manner it serves to set the framework within which departmental structures may be established. In addition, lines of authority are presented, as are relationships with other departments and groups, an indication of the minimum essential requirements for approval by accrediting agencies, extent of supervision and direction given personnel in the department, and the relative significance of the department within the over-all institution structure.

Again, in preparing the department descriptions, it was necessary to think of a composite hospital. All functions performed in patient care, research, preventive health services, and education and training, were first listed. Obviously all hospitals do not perform all these functions nor are all the facilities and classifications of personnel available. The descriptions, therefore, reflect a hospital giving complete service and hence is likely to be a large hospital. In the descriptions, each function or service is organized as a separate department. Each of these will be telescoped to a varying degree according to the degree of completeness of service in each hospital.

An attempt has been made to show relationships and areas where functions and responsibilities might be combined in the small hospital. The reader will find the functions of anesthesiology, radiology, electroencephalography, electrocardiography, and physiatrics described as organized sections with a physician staff member assuming administrative and professional authority. It is recognized that such an internal structure does not exist in the smaller hospital. In these instances, technicians, nurses or other qualified persons will be delegated administrative responsibility, with professional practices established and supervised by a member of the visiting medical staff.

While this might seem an academic or unrealistic approach, it seemed necessary to develop a logical and definitive division of highly organized departmental functions, in order to establish a sound guide for use by all hospitals.

Organization Charts

Each departmental description is accompanied by an organization chart of that department. The organization charts reflect the points that have been made in the preceding statements regarding the departmental descriptions. The charts are not neces-

sarily reflections of the structure existing in any specific institution but present the pattern imposed by the specific jobs covered in this study.

Many hospitals do not employ the variety of types of workers shown by the job titles included on the charts. Others, where it is necessary to perform all the tasks mentioned in the various descriptions, will combine jobs in order to conserve space and personnel. (The complete volume will include a job description of each of the job titles shown in the organization charts.)

The organization charts reflect lines of authority and areas of supervision. In this respect they tend to highlight possible organizational defects such as ill-defined or overlapping lines of supervision with attendant loss of operating efficiency and morale. The charts also present a picture of the department as an integral, functioning part of the total operation of the institution.

In departments where the department head reports to one of the two ASSISTANT ADMINISTRATORS, as designated in the organization chart headed "Executive Office," the words *professional* or *business and operating divisions* will be found. These same headings are shown wherever the ASSISTANT ADMINISTRATOR is the administrative authority in the chain of command.

No organization chart of the total hospital has been prepared, again because of the many variables existing among hospitals. Clerical positions cut across departmental lines and usually occur in almost every department. Clerical positions, for this reason, have not been shown on the charts. No organization chart has been prepared for the outpatient department since this would be repetition, on a smaller scale, of the entire inpatient organization structure.—ANN S. FRIEND, *personnel specialist, American Hospital Association.*

★ ★ ★

The Hospital

THE HOSPITAL is a complex organization utilizing combinations of intricate, specialized scientific equipment, and functioning through a corps of trained technicians educated to the problems of modern medical science. These are all welded together in the common purpose of restoration and maintenance of good health.

The hospital, as an organization, provides special facilities and trained personnel to facilitate the work of the physician in his primary position in the care of the patient. The patient is the focal point about which all activities of the hospital revolve. The character and extent of hospital services are adjusted continuously to keep abreast of changes and advances in medical science. This requires frequent replacement and addition of equipment, effective on-the-job training opportunities, and integrated departmental organization.

Although primary emphasis is placed on the care of bed patients, the frontier of the hospital in recent years has been extended from the sick person in the hospital bed to the potentially sick person in his normal living situation. Hospitals have been assuming more and more responsibility for programs of preventive medicine. They serve as the medium in many communities through which physicians and nurses, as well as voluntary and official health agencies, pool their efforts for improvement of the public health. This public education aspect of hospital service is rapidly becoming an important aspect of the service rendered to the community by the hospital.

An important corollary function of the hospital is the education of both professional and nonprofessional staffs. The medical and nursing professions, as well as a number of other vocations, depend upon the hospital for education and training. The hospital is the only locale in which students of medicine and nursing can obtain the broad practical experience that is necessary to supplement and round out their academic instruction. In many instances this applies equally to the business, administrative, and service staff of the hospital. Technicians of all types must keep abreast of advances in their respective fields and these advances occur within the hospital. Only there can they obtain the requisite on-the-job training necessary to familiarize themselves with new developments. The educational and training programs for each of these groups requires planning, organization and direction. They all have a bearing upon the hospital's service. They all must be fitted into the overall operation of the hospital.

Another broad function of the hospital is to facilitate investigative studies and research in the fields of medical services and concern itself with improving administrative procedures. Some hospitals have the resources and facilities to support an effective program of basic research. In these, it is necessary to integrate the work of the scientist and the clinician in order to provide opportunity for the development of projects of fundamental research and to apply the knowledge gained in the practice of medicine.

In most hospitals, opportunities are present for the conduct of clinical studies. Valuable data is accumulated in the medical records of the thousands of patients cared for in hospitals. This data must be used to test the hypothesis and the scientific investigations which result from fundamental research. Most hospitals continuously encourage the conducting of formal or informal research programs designed to improve the over-all services which hospitals make available to the public.

Thus, the hospital brings together various types of personnel and facilities for use by the physician. Here then is combined specific life-saving efforts with related public health, educational and research activities. Although there is no typical hospital which reflects the special emphasis placed on the various phases of their comprehensive health programs, all participate to some degree in all of the related activities. Hospital personnel must work, therefore, in an atmosphere of coordinated effort of trained and experienced technicians whose interlocking efforts reflect the unusual breadth and depth of hospital functions.

In some aspects, the hospital resembles and incorporates activities usually found in most commercial enterprises. In addition to the business, administrative and service departments commonly found in commercial enterprise, the hospital usually includes a laundry, a power plant, a dietary service, a paint shop and a maintenance staff. In this regard, a hospital incorporates industrial functions, but the similarity does not extend through its entire organization and operation.

Industry is created through individual initiative to provide a service or product which can be sold for profit. Hospitals are established as a result of group effort to provide a public service.

Industry produces tangible goods which it offers to the public at an established price and which the public accepts or rejects according to its desire for the product and judgment of the quality and cost of the item. Hospitals provide facilities and personnel for a personal service which the recipient usually does not elect to receive, which he often does not understand, which he is anxious to forget, at a cost which is not predictable.

Industrial efforts are built upon regular time schedules and carefully established production processes. Work programs of employees can be specific and binding. Flow charts and measures of production are useful and necessary. Hospital staffs must be organized to meet emergencies rather than to follow routine production schedules. This requires constant

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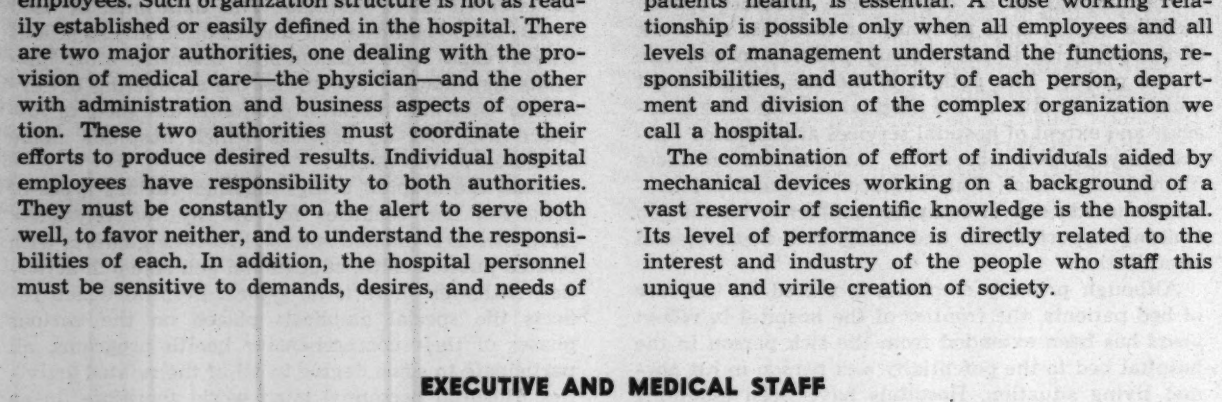
program planning, some personal sacrifices, and extended hours of work on occasion. The hospital functions 24 hours each day, seven days each week, and 52 weeks each year. Hospital employees deal continuously with people who are emotionally and physically upset so that their technical and mechanical skills must be fitted within a framework of quiet persuasion and full understanding of abnormal human behavior.

Industry relies upon a clearly established direct line of authority from top management to production employees. Such organization structure is not as readily established or easily defined in the hospital. There are two major authorities, one dealing with the provision of medical care—the physician—and the other with administration and business aspects of operation. These two authorities must coordinate their efforts to produce desired results. Individual hospital employees have responsibility to both authorities. They must be constantly on the alert to serve both well, to favor neither, and to understand the responsibilities of each. In addition, the hospital personnel must be sensitive to demands, desires, and needs of patients and their relatives so that their satisfaction is assured. To this end, hospital employees must work to maintain a unity of purpose within their organizations.

If the greatest possible values are to accrue from the efforts of hospital employees, awareness and continuous emphasis on problems of human relationships among medical staff members as well as between hospital personnel and patients are necessary; and a coordinated team effort to accomplish the end objective of hospital care, and the restoration of the patients' health, is essential. A close working relationship is possible only when all employees and all levels of management understand the functions, responsibilities, and authority of each person, department and division of the complex organization we call a hospital.

The combination of effort of individuals aided by mechanical devices working on a background of a vast reservoir of scientific knowledge is the hospital. Its level of performance is directly related to the interest and industry of the people who staff this unique and virile creation of society.

EXECUTIVE AND MEDICAL STAFF


Board of Trustees
(Policy formulation and ownership)
Medical Staff
(Formulation of policies related to professional practice for presentation to the Board of Trustees.)
Administration
(Execution and interpretation of policies established by Board of Trustees through planning, organization, staffing, direction and control)
Executive Committee
Medical Staff
Professional
ASSISTANT ADMINISTRATOR
Chief Resident
Interns
Residents

Executive Office

PURPOSE: Direct all functions of the hospital in keeping with over-all policies established by the governing board, in order that objectives of service to the sick, advancement of knowledge, and over-all contribution to community welfare may be achieved most effectively, economically, and to the satisfaction of patients, employees and medical staff.

RESPONSIBILITY FOR: As the administrative arm of the hospital, the executive office functions in two basic ways; namely, to interpret and administer policies of the governing board, and to act as technical adviser and liaison officer in matters involving formulation of these policies. To execute these functions properly, the department is responsible for management and supervision of all aspects of the hospital's activities, including planning and direction, public relations, budget and finance, personnel administration, purchase and supply, plant maintenance, housekeeping, and general administrative services.

More specifically, responsibilities of the executive office include:

1. Transmitting and interpreting policies, rules,

and regulations affecting all hospital activities and personnel; establishing procedures for systematic performance of hospital duties, and coordinating activities of all departments.

2. Acting as liaison between governing board and hospital medical staff. Administration encourages professional and medical standards through an insistence on an organized medical staff prepared to take care of studying necessary quality standards. The ADMINISTRATOR is the deputy of the board and acts for it in an executive capacity.

3. Providing for equipment and facilities consistent with community needs and goals of the hospital, and insuring that high professional standards are maintained for care of sick. The executive office has primary responsibility for safety and protection of hospital patients.

4. Formulating and maintaining a program of good public relations. This involves explaining hospital costs and functions to the public, interpreting the hospital's purpose and importance in relation to community welfare, assisting in solicitation of funds and volunteer services, and participating in community affairs.

5. Maintaining sound financial structure, including establishing fee schedules, providing for careful, economical, and safe administration of funds, and maintaining accurate records of hospital finances.

6. Formulating sound personnel policies and disseminating these policies to all hospital employees, developing an organizational structure with clearly defined lines of authority and areas of responsibility which will enable the employees to work together toward common objectives, selecting and training qualified department heads and coordinating all department activities, establishing lines of communication between administrative and line employees.

7. Supervising maintenance and protection of buildings and grounds, giving final approval on equipment and supplies, and contracting for new construction.

8. Keeping abreast of advances in management and business methods, technological changes, and economic and political trends, and broadening the perspective and scope of hospital services to meet expanding needs of the community.

9. Preparing periodic reports to the governing board covering progress and activities of the hospital.

10. Finally, in cooperation with all departments affected, the executive office prepares a budget for approval by the board, and drafts recommendations covering future operations of the hospital.

AUTHORITY: The ADMINISTRATOR reports directly to the governing board and is delegated authority for carrying out established policies, rules, and regulations of the board. The guiding and directing force for administration emerges from the governing board, as the primary policy-determining body. The board specifically expresses the aims and goals it desires to achieve. The ADMINISTRATOR assists the board in this policy determination and usually initiates action on many matters which require an expression of policy. He develops, in cooperation with his immediate staff, the first statement of policy for consideration and approval by the board. In addition, constant review and periodic alteration of policies is essential. Once policies are determined, the ADMINISTRATOR is delegated full authority to conduct activities of the hospital in such a way as to achieve results desired. The ADMINISTRATOR, in turn, should delegate to his department heads the same authority over their respective departments.

INTER- AND INTRA- RELATIONSHIPS: Because ultimate responsibility for all hospital activities rests with the ADMINISTRATOR, coordination of various sections or departments is one of the major functions of the executive office. To do this, the executive office must maintain close contact with all departments of the hospital.

This office deals both directly and indirectly with problems affecting patients, visitors, employees and the medical staff. The education and training functions of the hospital require careful organization and follow-up of all programs to insure that minimum standards are achieved and maintained. The personal contacts between the ADMINISTRATOR and the governing board, medical staff, department heads, auxiliaries, patients, public health officials, civic organizations, and numerous other groups and individuals typify interrelationships inherent in activities of the executive office.

STANDARDS: Certain minimum standards for medical and professional care established by the American College of Surgeons, American Medical Association, American Hospital Association and other accrediting agencies are obligatory for many departments or units of the hospital. Others serve as guides in developing and maintaining an accepted level of performance. All standards must be thoroughly understood to insure conformance.

In addition, the American College of Hospital Ad-

General Clerical Section*

CLERK, GENERAL OFFICE

CLERK-TYPIST

SECRETARY

SECRETARY, MEDICAL

STENOGRAPHER

TYPIST

*These jobs, or combinations of these jobs, are found in almost every hospital department. They are assembled here as a fairly homogeneous group to avoid repetition in each of the departments and therefore do not appear in any organization chart.

Communication Section*

Elevator operator

Information clerk

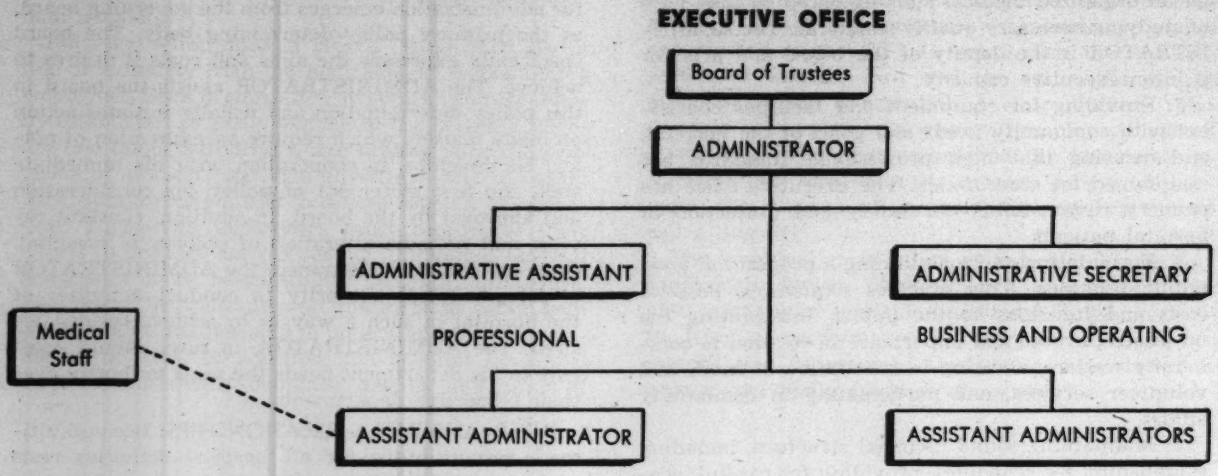
Messenger

Telephone operator

*These jobs may be assigned to any one of a number of departments and have therefore been omitted from the organization charts.

ministrators encourages increasing efficiency of hospital administration by promoting educational programs for training hospital administrators. Adherence to an established code of ethics is also encouraged.

STAFFING: The staffing pattern of the executive office will vary in accordance with size, type, and activity of the hospital. In a small institution the ADMINISTRATOR frequently attends to details in many or all functional areas. In the large hospital, the ADMINISTRATOR hires qualified section or department heads and perhaps one or more assistants in several of the primary administrative areas.



Admitting Department

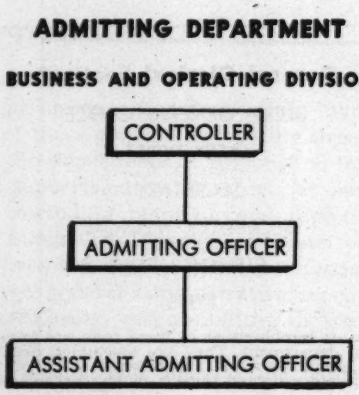
PURPOSE: Admit patients to the hospital, in accordance with policies and regulations established by the governing board and executive office, in such a way as to promote good relationships with patients, relatives, and medical staff.

RESPONSIBILITY FOR: Determining medical, financial, and geographical eligibility of patients for admission to the hospital. The department evaluates each applicant in terms of stated purposes of the hospital; controls number and types of patients admitted; admits patients to various services promptly, graciously and in an orderly manner; maintains records of patients awaiting admission and those already in the hospital, and develops a feeling of confidence in and understanding of activities of the hospital on the part of patient and general public.

Admitting functions revolve about admitting, transferring, and discharging of patients. Pre-admission reservations of an accommodation are made at the request of a member of the medical staff, except for emergency patients who are admitted in accordance with existing policy. Personal and statistical information is secured from the patient or a relative, and necessary financial arrangements are completed. The patient is furnished with information regarding activities and rules of the hospital and is referred or escorted to accommodations. All departments concerned with care, treatment, diagnosis, or record keeping are notified of admission of the patient. It is frequently the assigned responsibility of the admitting department to schedule use of operating room facilities and give out routine information concerning condition of patients.

AUTHORITY: The admitting department may be organized in a number of ways, depending on the size of the institution and the average number of admissions. In the large hospital, the admitting function is usually under the direction of an ADMITTING OFFICER who is responsible to the CONTROLLER. In the smaller hospital, admitting may be combined with some related function as indicated below.

INTER- AND INTRA-RELATIONSHIPS: Admitting office personnel represent the initial contact made by a patient upon entering the hospital. The impression created during this interview has a tremendous impact on the attitude of both patient and relatives. In allocating beds and making reservations at the request of members of the medical staff, the department also assumes an important role in establishing good hos-



pital-staff relationships. In addition, the department has contact with the business and medical records departments (in order that accounts and records may be started) and with the clinical laboratories department, dietary department, resident or attending physician, and nursing service department in order that the treatment process may be set in motion.

PHYSICAL FACILITIES AND STAFFING: The admitting department should be located near both the hospital entrance and business offices. Reception rooms should be pleasant and have an air of warmth and cheerfulness. Privacy for the patient and relatives while in the admitting office is essential.

The ADMITTING OFFICER may supervise a number of ASSISTANT ADMITTING OFFICERS and clerical assistants. In the smaller hospital, admitting functions may be performed by a member of the staff whose time is divided between admitting and such related functions as credit, information, or medical records. Personnel should be thoroughly trained in hospital policies and procedures and should display tact and courtesy in all dealings with the public.

Anesthesiology Department

PURPOSE: Provide for administration of all anesthetics used in the hospital, and contribute to treatment of patients and advancement of knowledge of use of drugs and anesthetics.

RESPONSIBILITY FOR: Anesthesiology service in surgical, obstetrical, and related medical procedures. The anesthesiology department is responsible for obtaining a physical examination, including clinical laboratory findings, of each patient before an anesthetic is administered; recording kind and amount of anesthetic administered, patient's condition before, during, and after anesthesia, and preoperative and postoperative medication; observing patient's condition until all effects of anesthesia have passed; evaluating effectiveness of anesthetic used and caring for equipment; and establishing and carrying out safeguards in administration of anesthetics.

AUTHORITY: A physician trained in anesthesiology usually directs activities of this department. He reports to the ASSISTANT ADMINISTRATOR for administrative responsibilities and to the chief of the medical staff for professional practices and has full authority over administration of anesthetics in the hospital. While standardizing agencies recommend medical supervision, in the absence of a medical anesthesiologist the surgeon is encharged and the division of the above duties is at his discretion—between the nurse anesthetist and the attending surgeon.

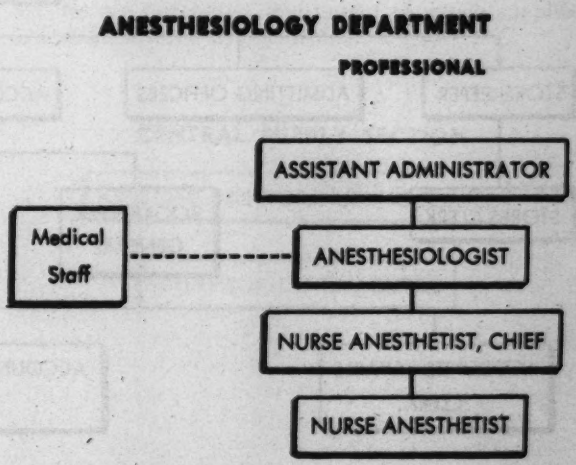
INTER- AND INTRA-RELATIONSHIPS: Personnel in the department must work closely with surgical, obstetrical, and X-ray services of the hospital. The ANESTHESIOLOGIST attends regular medical staff meetings, participates in discussions, and presents records of the department as a contribution to clinical research.

STANDARDS: Minimum standards have been formulated by the American College of Surgeons for the safety and efficiency of anesthesiology service in the hospital. These include requirements pertaining to organization, personnel, pre-anesthetic examination, records, follow-up, and safeguards.

PHYSICAL FACILITIES AND STAFFING: In a large hospital with a fulltime ANESTHESIOLOGIST, an office should be made available for his use near the operating room suite. Space for storing anesthesiology equipment and supplies also is located in or near the operating room.

Due to hazards involved in improper use of anesthetics, it is necessary to insure safety of all personnel and patients in accordance with precautions recommended by the National Fire Protection Association. Explosive anesthetics are stored in a fire resistive room. To prevent accumulation of static electricity, operating room equipment and personnel should be grounded through suitably conductive floors. The possibility of sparks from electrical connections and switches must be eliminated. Open flames should be prohibited within the area, as should the practice of smoking near the operating room.

An organized department of anesthesiology should be under direct supervision of a physician. In the smaller hospital, this service may be supervised or assigned to a staff physician who has had special training in the field. NURSE ANESTHETISTS qualified to administer anesthetics should be available to assist in carrying on work of the department and the CHIEF, NURSE ANESTHETIST, may be assigned administrative duties. In some instances, an ANESTHESIOLOGIST may devote part-time to two or more hospitals, and supervise NURSE ANESTHETISTS in instances where the volume of work is insufficient to require a full time ANESTHESIOLOGIST.



Business Department

PURPOSE: Manage the hospital's business activities and keep the administration informed of financial condition of the institution.

RESPONSIBILITY FOR: The business activities of the hospital which encompass receipt of revenues and expenditure or conservation of hospital funds. As a basis for performing these and related administrative functions, this department maintains extensive accounting and statistical records. It records all financial transactions including control of cash, recording of income and expense, recording of purchase and disposal of capital assets, estimate of cost of free service rendered indigent patients, and related transactions. The responsibility for development of payroll records and payment of salaries is likewise included here.

It is also a function of the business department to assist in preparation of budgets for ensuing fiscal periods. Among the many factors considered in preparation of a budget are estimated needs of various departments, departmental expenses of previous periods, anticipated patient census and income, and general economic and market conditions.

Similarly, the business department is responsible for preparation of reports of departmental income and expenses and for comparisons of gross earnings and costs of main revenue-producing departments. Such reviews and reports are of assistance in setting fee schedules.

In most hospitals, this department is charged with responsibility for determining the patient's ability to pay established rates for services rendered and for making necessary financial adjustments if the patient cannot meet full obligation. Included in this credit function is also the responsibility for collecting unpaid bills. In some hospitals, business activities are considered to include admitting functions.

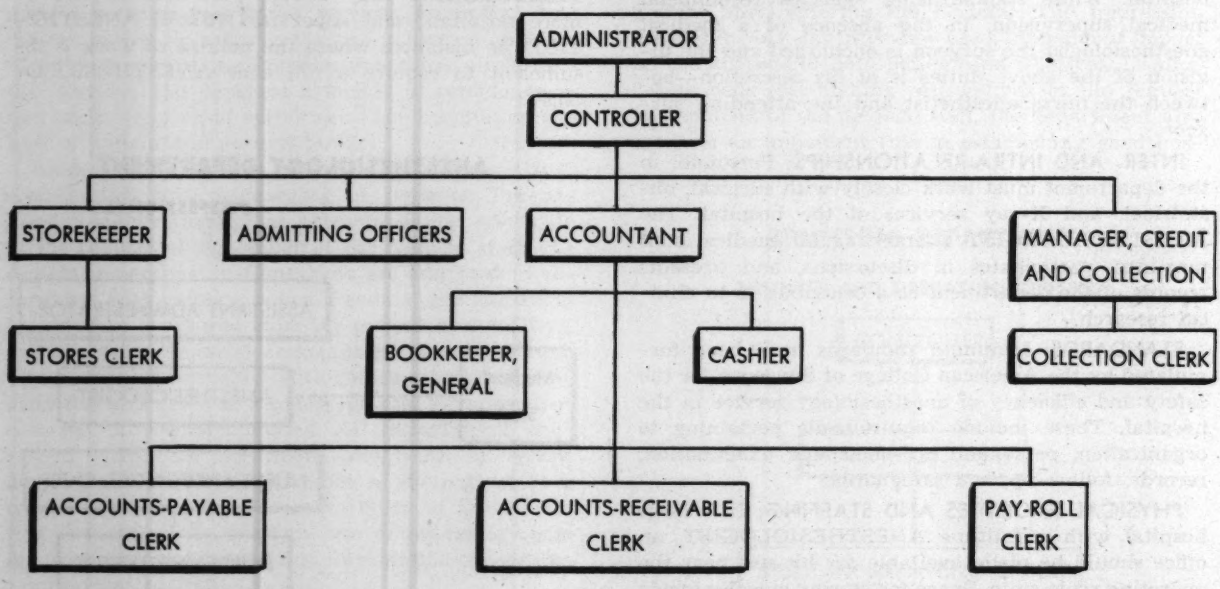
Storage and issuance of supplies and equipment is properly assigned to the business department, and frequently subordinate functions of telephone service, information, and message service become its responsibility too. Many of the functions of this department, particularly as pertain to accounts payable, deal with purchasing matters. In many institutions, therefore, purchasing procedures are included in the business department. (See "Purchasing Department.")

AUTHORITY: The business department is the center of operation of all financial affairs of the hospital, with the possible exception of purchasing. The large institutions may have an ASSISTANT ADMINISTRATOR who is directly responsible for management of the business office and indirectly, through heads of departments, for functioning of related activities outside the actual business office. Usually the head of the business department is designated as the CONTROLLER.

INTER- AND INTRA-RELATIONSHIPS: In carrying out its duties the business department must contact not only the general public but every department within the hospital as well. These contacts involve direct dealings with the governing board; patients;

BUSINESS DEPARTMENT

BUSINESS AND OPERATING DIVISION



medical staff; executive committees; local, state and federal health agencies; and numerous other groups, agencies, and individuals.

STANDARDS: Complete accounting records are vital in describing the status and activity of the institution. To facilitate accounting procedures in hospitals, the American Hospital Association has developed a manual of recommended accounts and statistical records to serve as a basis for developing a sound hospital accounting system.

PHYSICAL FACILITIES AND STAFFING: Well equipped and conveniently located offices must be provided. The department should have convenient access to the general public and to various departments of the hospital, but much of its work requires a degree of concentration which demands privacy and isolation from frequent interruptions. Present-day accounting and other business procedures demand mechanization for efficiency even in the smaller hospital. Consequently, most hospital business departments utilize typewriters, adding machines, calculators, and similar equipment.

The department is organized in a variety of ways depending on the size of the hospital. Supervised by a CONTROLLER, it may be subdivided into a number of separate sections such as accounting, payroll, admitting, and credit and collection. In smaller hospitals, some or all of these functions may be found combined. For example, the ADMINISTRATOR may act as CONTROLLER, and an ACCOUNTANT or BOOKKEEPER, GENERAL, may be employed to discharge the record-keeping function. CASHIERS, BOOKKEEPERS, CLERKS, and SECRETARIES are employed to handle clerical and other routine procedure.

Central Supply Section

PURPOSE: Centralize the storage, issuance, and preparation of nursing supplies and equipment used in care and treatment of patients in order to save time, money, and equipment and to provide a more effective supply service.

RESPONSIBILITY FOR: Requisitioning, storing, issuing, sterilizing, and manufacturing such equipment and material as is required for care of the patient. The section stocks hundreds of items which are issued, upon written request, to various nursing units. Some articles are issued infrequently or for temporary use, and others are issued routinely. Many hospitals have established systems of regularly scheduled deliveries to floors of common-use items. Only emergency requisitions are then filled during other periods of day.

The section is also responsible for maintaining a perpetual inventory of each item stocked, in order to assure adequate levels of supplies. Articles consumed are charged against the using patient or department. All equipment and supplies for bedside treatment, and frequently for the surgical department as well, are sterilized in a special room maintained for that purpose. Sterile water, distilled water, and similar items are likewise prepared in the central supply section.

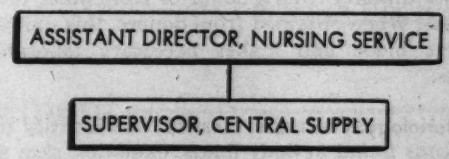
AUTHORITY: The SUPERVISOR, CENTRAL SUPPLY, reports to the ASSISTANT DIRECTOR, NURSING SERVICE, and must have the authority necessary to maintain an effective service for various nursing units.

INTER- AND INTRA-RELATIONSHIPS: Central supply operates as a staff function providing a service to nursing units of the hospital. Close cooperation with nursing units is, therefore, necessary. Student nurses are assigned to the supply room as part of their training. This requires coordination with the school of nursing in assigning personnel and conducting courses of instruction.

PHYSICAL FACILITIES AND STAFFING: The central supply section should be located centrally to the wards which it serves. The number of workrooms and amount of storage space required will be determined by size of hospital and degree of centralization. Dumbwaiters and pneumatic tubes are becoming standard equipment in the new hospital to facilitate service and reduce time spent in transportation of needed supplies. A central supply section may require separate areas for issuing, receiving, nonsterile supply, sterilizing, sterile supply, utility, glove preparation, dressing preparation, and solutions.

This section is headed by a SUPERVISOR, CENTRAL SUPPLY, who is usually a graduate nurse. She supervises specially trained workers. The size of her staff will depend on size of hospital, degree of centralization of supply, extent to which ready-made articles are purchased, and extent to which supplies are manufactured by the section.

CENTRAL SUPPLY SECTION



Clinical Laboratories Department

PURPOSE: Perform laboratory tests necessary for diagnosis and treatment of hospital patients, and engage in research essential to medical advancement.

RESPONSIBILITY FOR: Performing laboratory tests in five main fields of bacteriology, biochemistry, histology, serology and hematology, to assist the medical staff in making or confirming diagnoses. In addition to specialized tests, clinical laboratories in all general hospitals are responsible for making such routine tests as are agreed upon by medical staff and hospital administration. These usually include urinalyses for all patients on admission, blood cell and hemoglobin count, and gross and microscopic examination of all tissues removed at operations. The laboratory also determines causes of communicable diseases and, upon request, renders bacteriological service as a control and continual check of all apparatus used for sterilization. In larger hospitals, the clinical laboratories department will be divided into a number of specialized units:

Histopathology: Prepare and examine tissue to provide data on cause and progress of disease; make microscopic examinations of tissue pathology; engage in research to develop new histopathological methods, and new stains to produce greater clarity during examination of special tissue structures or chemical components; perform autopsies and interpret autopsy findings, microscopic and gross, in clinical pathological conferences on the treatment of the patient.

Biochemistry: Perform chemical tests of body fluids and exudates to provide information for diagnosis and treatment of disease; investigate chemical processes involved in functioning and malfunctioning of the human body; and study effects of chemical compounds upon physiological and biochemical functions of the body to provide information on optimum methods of treating pathological conditions.

Hematology: Analyze and test blood specimens and interpret test results to provide a basis for treatment of diseases; and engage in research related to hematological methods and diagnosis.

The blood bank, in a hospital having these special units, is usually a part of hematology. The bank provides for storage and preservation of blood and plasma. Blood may be procured either directly from a donor or from other blood banks. When obtained from donors, this unit extracts blood and makes necessary laboratory tests.

Bacteriology: Cultivate, classify, and identify microorganisms found in body fluids, exudates, skin scrapings, or autopsy and surgical specimens to provide data on cause, cure, and prevention of disease; engage in research to develop new or improved bacteriological methods for discovering and identifying pathogenic organisms; and investigate biology, distribution, and mode of transmission of bacteria and nature and efficiency of chemotherapeutic treatment.

Serology: Prepare serums used to treat and diagnose infectious diseases and confer immunity against these diseases, and identify diseases based on characteristic reactions of various serums; investigate safety of new commercial antibiotic products and accuracy of therapeutic claims; direct immunology tests and injections; investigate problems of allergy; and conduct tests to determine therapeutic and toxic dosages and most effective methods of administration of serums, vaccines, antibiotics, antitoxins, antigens and related drugs.

The clinical laboratories department may be responsible for a number of other functions, such as basal metabolism tests; activities of clinical photographic laboratory, medical illustration unit, and morgue; and care and treatment of animals used in research. Teaching programs for student nurses, interns, residents and MEDICAL TECHNOLOGISTS also may be a function of this department.

AUTHORITY: The PATHOLOGIST is assigned authority and responsibility for organization and operation of all pathological services. He is director of the clinical laboratory and also hospital PATHOLOGIST. He reports to the ASSISTANT ADMINISTRATOR on administrative functions and supervises all personnel assigned to laboratory. For professional standards, the PATHOLOGIST is responsible to the chief of the medical staff. The TECHNICIAN, CHIEF, may be delegated certain administrative duties under the supervision of the PATHOLOGIST.

INTER- AND INTRA-RELATIONSHIPS: Laboratory services must be coordinated with all other diagnostic functions of the hospital. This requires consultation with members of the medical staff, the ASSISTANT ADMINISTRATOR, MEDICAL, or the ADMINISTRATOR, and other department heads. A system should be established for performing all routine tests within a specified period of time after admission of a patient. Emergency laboratory services, as needed, must be available on a 24-hour basis.

Laboratory services are important to the work of the outpatient department, and close cooperation is necessary between these services. Personnel in the laboratory are in constant contact with patients; medical, admitting, and nursing staffs; and with other employees. The PATHOLOGIST may lecture to students, professional societies, and organizations in the medical field. Cooperation with other department heads, private physicians, and personnel in other laboratories and related health fields is necessary. In the smaller hospitals, laboratory personnel may perform related tasks in radiology, electroencephalography, and electrocardiography.

STANDARDS: All regularly employed laboratory technicians should be on the registry sponsored by

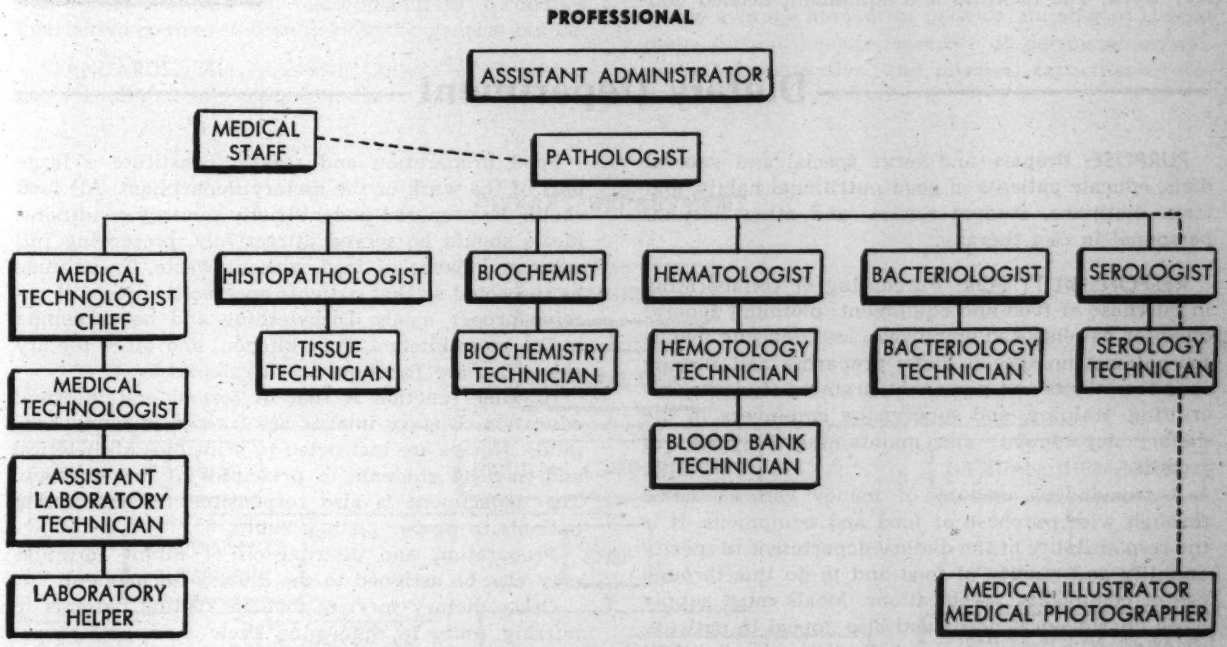
the American Society of Clinical Pathologists. They must have completed instruction in a school for technicians approved by the Council on Medical Education and Hospitals of the American Medical Association. Many hospitals, particularly those connected with schools of medicine, offer courses in medical technology. These schools also must meet the standards formulated by the Council on Medical Education and Hospitals of the American Medical Association.

PHYSICAL FACILITIES AND STAFFING: The physical facilities of this department will depend on its work load. The very small hospital which performs only routine examination in its own laboratory will require a minimum of space and equipment. In the large hospital, the laboratory space may be divided into a number of subdivisions, including an office for the PATHOLOGIST and a central workroom for such facilities as may be utilized in common by all laboratory units. Where a great deal of outpatient work is performed, a small branch laboratory may be set up in the outpatient department for the performance of routine tests.

The director of this department is a doctor of medicine who has qualifications in pathology acceptable to the Council on Medical Education and Hospitals of the American Medical Association. Where it is not possible to secure the fulltime services of a PATHOLOGIST, arrangements should be made for the services of a PATHOLOGIST for tissue and post-mortem examinations and for the interpretation of tests and examinations.

Depending upon the hospital, requirements for a clinical laboratory director can be met by (a) A fulltime clinical PATHOLOGIST; (b) a part-time clinical PATHOLOGIST (frequently, arrangements can be made for a PATHOLOGIST to serve two or more hospitals within a given area); (c) a consulting PATHOLOGIST to whom materials can be sent for diagnosis and who will come to the laboratory periodically to supervise the services and meet with the medical staff; or (d) a member of the medical staff who has had training in clinical pathology who will direct the laboratory in those cases where the volume of work is insufficient to warrant the fulltime services of a specialist. In the latter instance, tissue examinations requiring extensive equipment and skill can be sent to the nearest clinical laboratory which is headed by a qualified PATHOLOGIST.

CLINICAL LABORATORIES DEPARTMENT



Dental Department

PURPOSE: Provide dental care and treatment for hospital patients and personnel.

RESPONSIBILITY FOR: (1) Developing and conducting a dental care program which includes diagnosis, prophylaxis, and treatment; (2) providing consultation and advice to clinicians, and correlating diagnosis and treatment with those of other departments; (3) planning and conducting an internship program in dentistry; (4) planning and carrying out research related to dental pathology, either independently or in

cooperation with personnel of other departments; and (5) providing records and reports of dental care activities.

AUTHORITY: The department should be under the direction of a licensed DENTIST, who usually reports to the ASSISTANT ADMINISTRATOR on administrative matters and to the chief of the medical staff on professional standards. The head of the department has authority over technicians and other personnel assigned to the service.

INTER- AND INTRA-RELATIONSHIPS: Personnel of this service should establish and maintain relationships with most clinical and administrative activities of the hospital, and with various outpatient services as well. DENTISTS attend and participate in regular hospital staff conferences, and opportunity should be afforded to dental interns and residents for training in general anesthesiology, physical diagnosis and other phases of medicine related to dentistry.

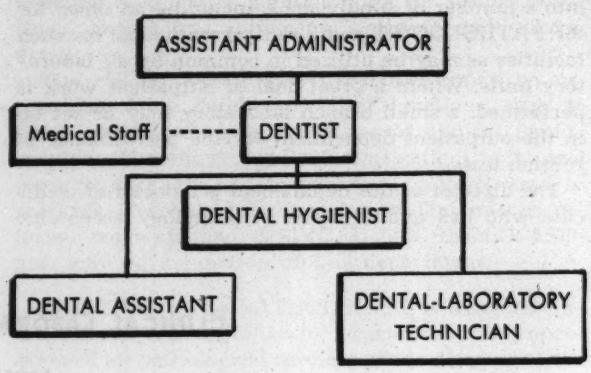
STANDARDS: Basic standards of hospital dental service required of approved hospitals have been formulated by the Committee on Hospital Dental Service of the American Dental Association. These standards cover organization, staffing, and administration.

PHYSICAL FACILITIES AND STAFFING: The dental department should be a complete and self-contained unit equipped for diagnostic, operative, and laboratory work. The facilities and equipment needed will depend on volume of dental work from both inpatient and outpatient services.

The DENTIST in charge of the program is a graduate of a school approved by the Council on Dental Education of the American Dental Association, or the National Dental Association. Wherever possible, DENTAL HYGIENISTS should be appointed to the department. Dental interns and residents are appointed according to established hospital regulations governing intern and resident appointments.

DENTAL DEPARTMENT

PROFESSIONAL



Dietary Department

PURPOSE: Prepare and serve special and general diets, educate patients in good nutritional habits, and train dietitians, student nurses, and other hospital personnel in diet therapy.

RESPONSIBILITY FOR: Purchasing or collaborating in purchase of food and equipment; planning general diets for patients and employees, and devising menus for patients on special diets; preparing and serving food to patients and personnel; training students; recruiting, training, and supervising employees in the dietary department; and maintaining a system of records.

A tremendous amount of money can be saved through wise purchase of food and equipment. It is the responsibility of the dietary department to specify quantity and quality of food and to do this through use of commodity specifications. Meals must supply basic physiological needs and also appeal to patients. For efficiency in operation, all diets can be built around general diets by additions and modifications.

A recipe file is maintained to facilitate preparation and cost control. The recipe cards should contain formulas to be followed and indicate yields in terms of number and size of servings, and costs of both total recipe and single servings. A diet manual, prepared by the dietary department in cooperation with a committee of the medical staff, should be available for use by physicians, residents, interns and nurses.

Food preparation and service constitute a large part of the work of the dietary department. All food should be prepared under strictly sanitary conditions. Meals should be served attractively, preserving full color and flavor of food without waste. Trays must be inspected so that patients on special diets will receive proper meals. Dishwashing and housekeeping in the main kitchen, floor kitchen, and other dietary areas also are functions of this department.

Another function is that of formal and informal education. Dietary interns are trained in many hospitals. Nurses are instructed in principles of dietetics, and medical students in principles of diet therapy. The department is also responsible for instructing patients in proper dietary habits.

Preparation and distribution of infant formulas may also be assigned to the dietary department.

Other dietary services include visiting patients in nursing units to determine their food preferences both as to type of food and manner in which it is prepared; advising patients with special dietary problems after their discharge from the hospital, or as referred from the outpatient clinic; cooperating with medical staff in planning, preparing, and serving experimental diets.

Dietetics is an important aspect of hospital medical care. To be effective, the dietary department must develop a planned program, efficient organization and administration, and close coordination with other

hospital activities. The program must be flexible enough to take advantage of current developments in medicine and dietetics.

AUTHORITY: The dietary department is under the direction of a DIETITIAN, CHIEF, who reports directly to the ADMINISTRATOR. Administrative policies, budgetary controls, and procedures for carrying out the dietary program are determined by the ADMINISTRATOR in cooperation with the DIETITIAN, CHIEF, and other department heads involved. The DIETITIAN, CHIEF, is then delegated full authority for carrying out the dietary program.

INTER- AND INTRA-RELATIONSHIPS: The dietary department maintains operating relationships with most medical care and administrative activities of the hospital. Close relationships are maintained with medical staff on special dietary needs of patients in treatment of pathological conditions, with nursing services on provision of regular and special diets and between-meal nourishment, and with the ADMINISTRATOR on management matters such as personnel and financing purchase of supplies. In addition, the dietary department is in constant touch with both inpatients and outpatients. The department usually takes an active part in formal and informal educational programs of the hospital and thus comes in contact with physicians, interns, residents, nurses, student nurses, dietetic interns and other employees. The department may have an opportunity to conduct instructive courses in dietetics for the general public.

STANDARDS: The American College of Surgeons has formulated minimum standards for dietary departments in hospitals, which include standards on organization, facilities, personnel, records, and policies.

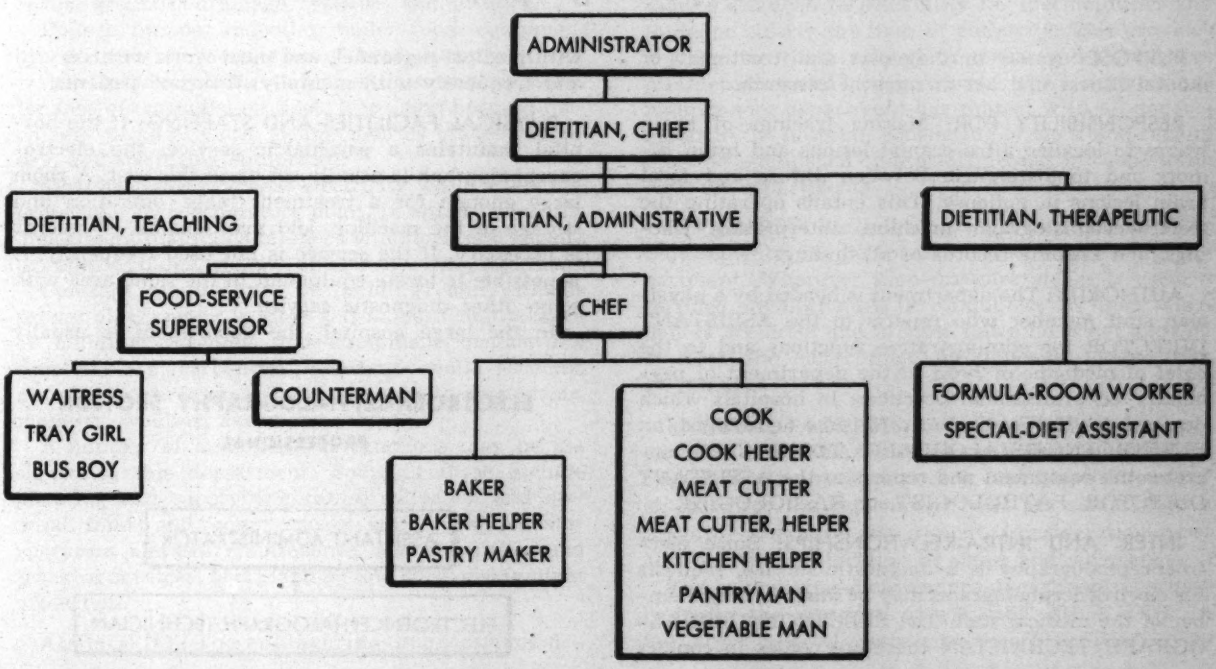
The American Dietetic Association has developed standards for training of dietary interns and has established specifications for a qualified hospital dietitian.

In most states, it is required by law that those concerned with food service shall be subject to physical examination to determine if they are free of communicable diseases.

PHYSICAL FACILITIES AND STAFFING: Modern food service in a hospital requires not only the necessary space for main kitchen, storage, refrigeration, special diet preparation, infant formula room, dining room for employees, and possibly a bake shop, but also should take into consideration such factors as location, utilities, transportation of food, garbage disposal, dishwashing and cleaning. Employee locker rooms and toilet facilities also are necessary. Careful consideration should be given to labor-saving devices and to location and arrangement of equipment.

A DIETITIAN, CHIEF, heads the department and must possess qualifications specified by the American Dietetic Association. The number of assistant dietitians and other employees such as CHEFS, KITCHEN HELPERS, MAIDS, MEAT CUTTERS, PORTERS, and WAITRESSES, are determined by such factors as the average number of patients, number of special diets, type of service, number of personnel served, extent of instruction, and physical capacities of the department.

DIETARY DEPARTMENT



Electrocardiography Section

PURPOSE: Assist in diagnosis of heart disease and aid in medical research of heart conditions.

RESPONSIBILITY FOR: Making mechanical tracings of heart cycle to aid in diagnosis of heart diseases. This entails operating the electrocardiograph machine, interpreting tracings, and keeping records of all findings.

AUTHORITY: The department is headed by a physician who reports to the ASSISTANT DIRECTOR on administrative matters and to the chief of medicine on professional practices. In the smaller hospital which may not require the services of a fulltime cardiologist, an ELECTROCARDIOGRAPH TECHNICIAN operates the equipment and reports to the ASSISTANT DIRECTOR, PATHOLOGIST, or RADIOLOGIST.

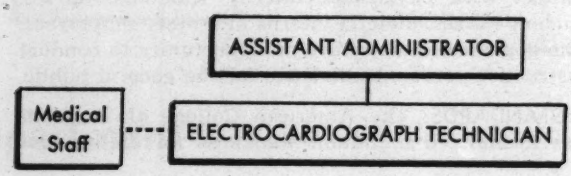
INTER- AND INTRA-RELATIONSHIPS: Since electrocardiology is a diagnostic service, requests for electrocardiograms will be made by any member of the medical staff. The ELECTROCARDIOGRAPH TECHNICIAN therefore comes in contact with medical personnel and must work with very ill and emotionally upset patients, and frequently meets relatives and friends of patients. Some contact with nursing personnel is also necessary and requires mutual understanding and cooperation.

PHYSICAL FACILITIES AND STAFFING: With the advent of portable electrocardiograph machines now used by most hospitals, it is not necessary to have large or elaborate space for the electrocardiography section. Storage space for equipment and records is necessary but this may be located in the same area with some other diagnostic service.

In the large hospital, the department is headed by a cardiologist who is a graduate of an approved medical school with qualifications acceptable to the Council on Medical Education and Hospitals of the American Medical Association, or by a physician with training and experience in the interpretation of electrocardiograms. A qualified ELECTROCARDIOGRAPH TECHNICIAN is employed to operate the machine and to develop (if necessary) the tracings. In many hospitals, an X-RAY TECHNICIAN, MEDICAL TECHNOLOGIST, or professional nurse is trained to take electrocardiograms.

ELECTROCARDIOGRAPHY SECTION

PROFESSIONAL



Electroencephalography Section

PURPOSE: Assist in diagnosis and treatment of mental illness and aid in medical research.

RESPONSIBILITY FOR: Making tracings of brain waves to localize intra-cranial lesions and brain tumors and to distinguish between diffuse and focal brain lesions in epilepsy. This entails operating the electroencephalograph machine, interpreting tracings, and keeping records of all findings.

AUTHORITY: The department is headed by a physician staff member who reports to the ASSISTANT DIRECTOR for administrative functions and to the chief of medicine or head of the department of psychiatry on professional practices. In hospitals which do not have the services of a fulltime neurologist, an ELECTROENCEPHALOGRAPH TECHNICIAN operates the equipment and reports to the ASSISTANT DIRECTOR, PATHOLOGIST, or RADIOLOGIST.

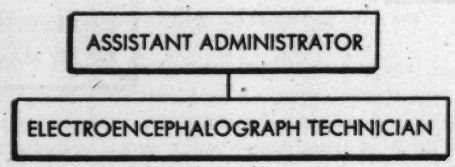
INTER- AND INTRA-RELATIONSHIPS: Since electroencephalography is a diagnostic service, requests for electroencephalograms may be made by any member of the medical staff. The ELECTROENCEPHALOGRAPH TECHNICIAN therefore comes in contact with medical personnel, and must work with very ill and frequently with mentally disturbed patients.

PHYSICAL FACILITIES AND STAFFING: If the hospital maintains a psychiatric service, the electroencephalograph is usually set up in this unit. A room large enough for a treatment table, operation and storage of the machine, and maintenance of records is necessary. If the service is not used frequently, it is possible to locate equipment in the same area with some other diagnostic service.

In the large hospital, the department is usually

ELECTROENCEPHALOGRAPHY SECTION

PROFESSIONAL



headed by a neurologist who is a graduate of an approved medical school with qualifications acceptable to the Council on Medical Education and Hospitals of the American Medical Association, or by a physician with training and experience in interpretation of electroencephalograms. A technician is employed to operate the equipment. In many hospitals, a MEDICAL TECHNOLOGIST; X-RAY TECHNICIAN, or professional nurse is trained to take electroencephalograms.

Engineering-Maintenance Department

PURPOSE: Provide services of light, heat, repair, and maintenance necessary for care of hospital facilities; and to create a pleasant and comfortable physical environment for patients, employees, medical staff, and general public.

RESPONSIBILITY FOR: Production of light, heat, service utilities and power, and their transmission to points of use is the assigned function of engineering. The function of maintenance concerns upkeep and repair of buildings and grounds and those pieces of equipment not cared for by using departments. Since engineering and maintenance functions and responsibilities overlap to a considerable degree, they are described here as a single unit. In many hospitals these functions are combined.

Engineering-maintenance functions include advising the ADMINISTRATOR on matters pertaining to light, heat, service utilities and power; establishing technical procedures and management functions pertaining to repairs and utilities; providing technical advice and assistance in case of loss, damage, or destruction of buildings; supervising and coordinating improvements of hospital plant, including landscaping, construction, and repairs; coordinating matters pertaining to major construction; establishing priority for repairs and utilities projects; and planning, programming, and accomplishing maintenance, repair, and improvements of buildings, structures, roads, grounds, drainage systems, and utilities.

Boilers, pumps, and other boiler room equipment are utilized for production of heat, steam, and hot water. Operation of this equipment also implies maintenance of transmission lines, traps, and hospital machinery using pressure steam, such as kitchen, laundry, and sterilizing equipment.

Most hospitals purchase electricity while a few operate their own generating plant. In either event, the department maintains all electric motors, and repairs or replaces plugs, sockets, extension wiring and fuses.

Constant maintenance of buildings and grounds proves an economy in time and money. Maintenance of buildings, grounds and equipment include the functions of carpentry, painting, wall washing, plumbing, gardening, furniture repair, plastering, masonry, welding, and many others.

A number of miscellaneous functions may be assigned to this department. Some of these include planning and supervising refuse collection and disposal; insect and rodent control; supervising elevator operators, elevator maintenance, and ambulance and trucking services; and planning and supervising plant protection.

AUTHORITY: The engineering-maintenance department is usually under the supervision of a CHIEF ENGINEER. In the larger hospital it is becoming the practice to centralize the functions of maintenance, engineering, housekeeping, and laundry under direction of a single individual who may be a graduate engineer or have had experience or training in administration. The position is comparable to that of ASSISTANT ADMINISTRATOR and is directly under the ADMINISTRATOR. In the smaller hospital, there may be a CHIEF ENGINEER who directs the engineering-maintenance activities and reports to the ASSISTANT ADMINISTRATOR or ADMINISTRATOR.

INTER- AND INTRA-RELATIONSHIPS: The departments of engineering, maintenance, housekeeping, and laundry are engaged in rendering nonprofessional services essential to hospital operation. These departments are found combined in a number of ways depending on the size of the hospital. While they have been discussed here as separate units for purposes of clarity, their individual functions and responsibilities overlap to a considerable degree, making clear-cut divisions difficult. In actual operation, complete departmentalization is not possible. At times the departments so interlock that they are indistinguishable from one another, but this should promote efficiency if personnel are not permitted to evade or shift responsibility. Regardless of the difficulty, it is necessary to establish responsibility for specific duties and to define clearly the lines of authority. This provides a guide for these related functions and encourages interdepartmental cooperation. The engineering-maintenance department has contact with all departments in the hospital. Scheduling of work and repairs must be established on a priority basis in cooperation with all departments.

STANDARDS: State laws are very specific in their requirements for personnel in the engineering department. Wherever high-pressure steam is used, a certified engineer must be on duty at all times when boilers are fired, and in most states he is not allowed to leave the boiler room for a period longer than 10 minutes.

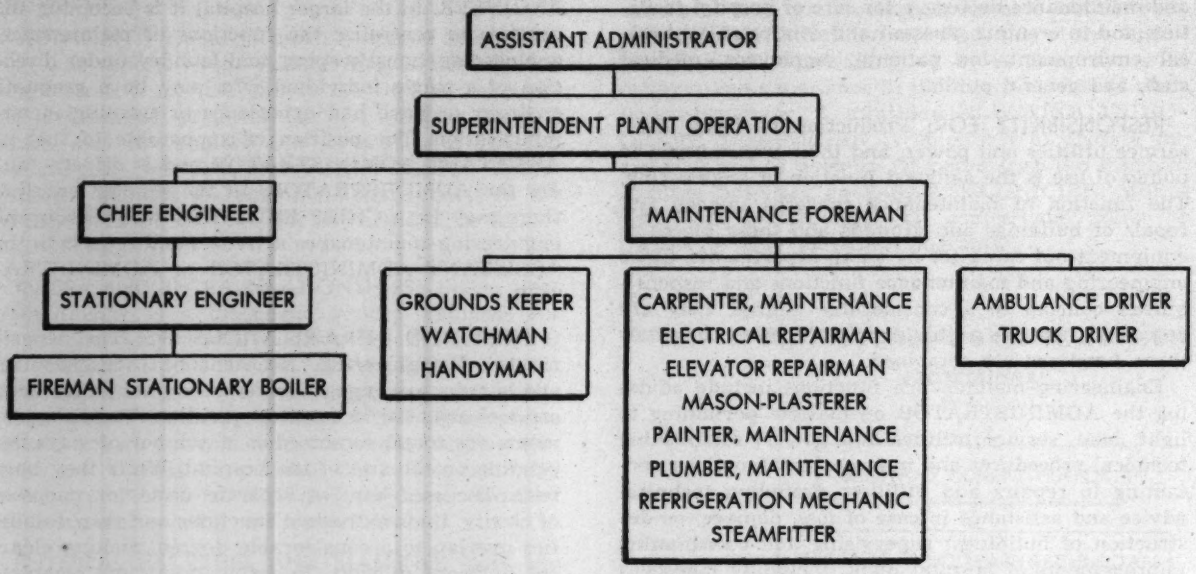
PHYSICAL FACILITIES AND STAFFING: A well organized, neatly kept storeroom; space for machine, electrical, plumbing, carpentry, and paint shops; and an office for the department head are essential to a smoothly operating department. Consideration must also be given to location of shops and storerooms.

The engineering-maintenance department is usually under the direction of a CHIEF ENGINEER. In the larger hospital, there may be a SUPERINTEND-

ENT, PLANT OPERATIONS, supervising a CHIEF ENGINEER responsible for engineering, and a MAINTENANCE FOREMAN in charge of maintenance. The department will have such additional personnel as carpenters, plasterers, painters, plumbers, electricians, steamfitter, stationary engineer, refrigeration mechanic, machinists, masons, elevator repairmen, truck drivers, and laborers. The number of personnel will depend on the size and needs of the hospital. Smaller hospitals which cannot employ an extensive staff combine jobs or utilize the services of private contractors.

ENGINEERING-MAINTENANCE DEPARTMENT

BUSINESS AND OPERATING DIVISION



Housekeeping Department

PURPOSE: Keep the hospital in a clean, healthful, and sanitary condition in order to provide an environment important to welfare and care of patients.

RESPONSIBILITY FOR: The clean, sanitary, pleasant environment essential to medical and nursing care of patient and to hospital staff as well. The responsibility for providing such surroundings in as economic a manner as possible, falls in a large measure upon the housekeeping staff of the hospital. Housekeeping is a complex activity requiring constant attention to many different details and an overall plan which provides for the utilization of personnel, procedures, and material in an efficient and effective manner.

The functions of the housekeeping service may be classed as internal administration, regular and special cleaning, decorating, and miscellaneous.

Internal administrative functions include determination and justification of personnel, equipment, and supply requirements; selection, training, disciplining, and supervision of housekeeping personnel; scheduling of work activities; study of new techniques for improving housekeeping service; requisitioning housekeeping supplies and equipment and reissuing these to personnel in other services responsible for housekeeping duties.

Regular and special cleaning duties include floor and wall care; cleaning and polishing furniture, fixtures, and furnishings; washing windows; cleaning and servicing washrooms; and picking up and disposing of garbage. The housekeeping department may advise and recommend redecorating and repairing of hospital premises and equipment. The responsibility for control of vermin, insects, and other pests also may be a housekeeping function.

The department maintains a sewing room for mending torn or worn linens. These linens are repaired, torn up for rags, or converted to smaller articles such as washrags, pillowcases, and related items. Repaired linens are returned for redistribution. Linens salvaged for other uses are replaced by new ones to maintain the level of stock.

The housekeeping department may be assigned the function of distributing linen throughout the hospital. This entails supply and control. Linens may be distributed through a centralized system in which a general supply is maintained and linens issued as needed, a decentralized system wherein each area of the hospital has its own supply of linens distinguished by specific marks, or a system which is a combination of the two.

The miscellaneous functions of elevator operation, and in some smaller hospitals operation of the laundry, may be assigned to the housekeeping department.

AUTHORITY: While the housekeeping function is performed within every department in the hospital, it should be the sole responsibility of the EXECUTIVE HOUSEKEEPER, who reports to an ASSISTANT ADMINISTRATOR. In the large hospital, there may be a superintendent of buildings and grounds who supervises maintenance, engineering, housekeeping, and laundry activities. In these instances, the head of the housekeeping department will report to the superintendent of buildings and grounds.

INTER- AND INTRA-RELATIONSHIPS: The cleanliness of rooms and corridors is important not only to attitude and safety of patients, but to prestige of the hospital as well. Cleanliness affects all service departments as well as those concerned with professional care of patients. Duties are planned so as to cause the least possible disturbance to patients and staff members and to provide a maximum of cooperation with other departments.

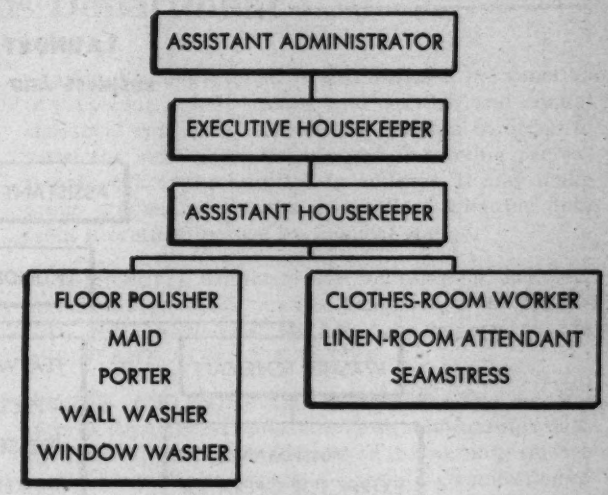
The housekeeping department must function in close cooperation with all departments, but particularly with nursing, laundry, and maintenance.

PHYSICAL FACILITIES AND STAFFING: The housekeeping department requires a number of special physical facilities. An office for the head of the department should be provided near the entrance through which employees enter and leave work. Her office should be large enough to permit interviews and conferences with employees and other department heads. There should be floor supply rooms and closets; shelving, and hooks in closets and storage rooms; locker, dressing, and rest rooms for employees; and repair sewing rooms.

The department is headed by an EXECUTIVE HOUSEKEEPER, who is responsible for training and supervision of MAIDS, PORTERS, JANITORS, WALL WASHERS and other personnel performing housekeeping tasks. In the large hospital, the EXECUTIVE HOUSEKEEPER will probably have ASSISTANT HOUSEKEEPERS. MAIDS and PORTERS should be assigned to specific duties. If dual authority and duplication of effort is to be avoided, division of work must be carefully coordinated. Assignments should be made specifically so that there will be no friction and no doubt as to the individual responsible. It should be pointed out that minor housekeeping tasks are necessarily performed by other than housekeeping personnel.

HOUSEKEEPING DEPARTMENT

BUSINESS AND OPERATING DIVISION



Laundry Department

PURPOSE: Collect and launder hospital linens and uniforms in order to provide adequate supplies of clean, sanitary linens to all using departments.

RESPONSIBILITY FOR: Collecting linens according to the particular system in use, checking for worn or torn spots, and weighing for production records. Linens are then sorted on basis of type of washing to be given. The total washing process, consisting of break, suds, rinse, blue, sour and starch, is carried on in rotating cylinders usually in accordance with standard formulas. Load limits for various pieces of equipment are predetermined to prevent improper washing and more rapid deterioration of machines and linens. After washing, laundry is placed in extractors for removal of water and is finished by one of three methods—(1) rough dry, (2) machine finished by a chest-type or a roll flatwork ironer, and (3) hand finished by press or by hand ironing.

In some hospitals, the laundry is assigned responsibility for storing, issuing, and inventorying all linens in order to maintain centralized control. In other hospitals, laundered articles are returned to the housekeeping department for distribution.

The laundry is a large item of expense and each institution must decide whether it is better economy to contract for the services of a commercial laundry or to operate its own department.

AUTHORITY: Practice varies as to whether the laundry functions as a unit of housekeeping or maintenance departments or as an independent but closely related department. When it exists as a separate department, the LAUNDRY MANAGER should have full authority over all laundry functions. He usually reports to the ASSISTANT ADMINISTRATOR, or in some instances, to a SUPERINTENDENT, PLANT OPERATION.

INTER- AND INTRA-RELATIONSHIPS: Because the laundry is usually located in the basement or separate building, laundry employees have less contact with other hospital employees, except those concerned with distribution, and little if any contact with patients. Therefore, every effort should be made to emphasize the importance of clean linens in care and treatment of patients and of coordinated effort required in providing adequate linens.

Linens are furnished to many departments and units of the hospital, necessitating close coordination between the laundry and various users of linens. Work schedules should be set up in cooperation with department heads and consideration given to over-all requirements and distribution of daily laundry load. The LAUNDRY MANAGER should recommend and advise on distribution and purchase of hospital linens.

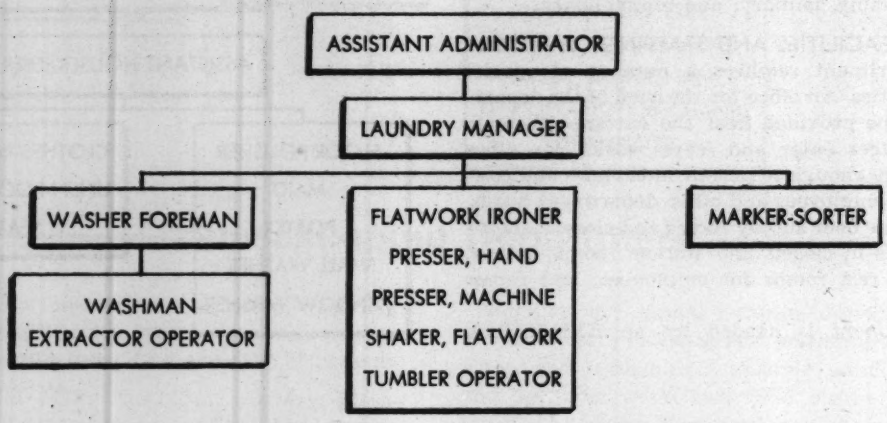
STANDARDS: The American Institute of Laundering and the laundry manual of the American Hospital Association ("Hospital Laundry Manual of Operation") recommend formulas to cover water levels, length of time, temperature, and kinds of washing operations needed for best laundering results, and supplies required for different types of linens in various degrees of soil.

PHYSICAL FACILITIES AND STAFFING: It is generally agreed that in all but the smallest institutions the hospital-operated laundry represents a saving in material, money, and efficiency. All equipment, however, should be balanced and conveniently located. In order to meet this requirement it is first necessary to know quantity and type of linen to be handled. From this, size and number of washers, capacity of extractors, and number of tumblers, flat ironers, and hand ironers can be estimated.

The department is directed by a LAUNDRY MANAGER, who supervises a number of machine operators depending on laundry load. In the smaller hospital, laundry personnel is utilized to assist in performing other duties during slack periods.

LAUNDRY DEPARTMENT

BUSINESS AND OPERATING DIVISION



Medical Library Department

PURPOSE: Make accessible to staff members medical literature on standard procedures and recent developments in medicine, surgery, and the various specialties.

RESPONSIBILITY FOR: Maintaining an up-to-date collection of periodicals, textbooks, and manuscripts on medical procedures and research, hospital administration, and national and community health programs. The library classifies, catalogs, and indexes all literature. It issues and arranges books on shelves. Such functions as binding of books and journals and assisting in preparation of bibliographies, abstracts, and reviews of literature also are performed in this department.

AUTHORITY: The medical library department is directed by a MEDICAL LIBRARIAN who reports to the ASSISTANT ADMINISTRATOR or to the ADMINISTRATOR. Authority for maintaining the library is delegated to the LIBRARIAN, but a library committee should advise on purchase of textbooks, reference works, monographs, and journals. The committee also helps formulate rules and regulations affecting use of the library.

INTER- AND INTRA-RELATIONSHIPS: The medical library provides reading room service, a lending service, and an inter-library loan service to staff members, residents, interns, nurses, and technicians. In addition, close relationships are maintained between librarian and library committee. This committee is usually made up of three to five persons selected from among members of medical staff, and an interested member of the governing board.

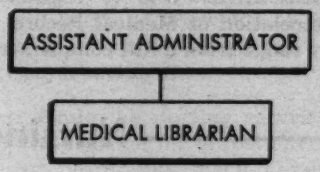
STANDARDS: Minimum standards for the hospital medical library department are incorporated in the minimum standards for hospitals of the American College of Surgeons. These standards include recommendations as to library collection, housing, personnel, extension facilities, and advisory committee.

PHYSICAL FACILITIES AND STAFFING: The medical library should be housed in, or adjacent to, a conveniently located reading room which is well lighted and equipped. Textbooks and bound journals should be classified and arranged on shelves so as to be easily accessible to the MEDICAL LIBRARIAN and members of the hospital staff. Current issues should be placed on open shelves or tables to attract attention of readers.

In the large hospital, the medical library is under supervision of a qualified MEDICAL LIBRARIAN. In most smaller hospitals, the MEDICAL-RECORD LIBRARIAN is responsible for activities of the medical library. In many instances, the nurses' and patients' libraries are located separately from the medical library, but usually are supervised by the same person.

MEDICAL LIBRARY DEPARTMENT

BUSINESS AND OPERATING DIVISION



Medical Records Department

PURPOSE: Provide a central file of medical records compiled during treatment of a patient that will be used as a permanent record in event of future illness, as an aid in clinical and statistical research, as an administrative tool for planning and evaluating the hospital program, and/or legal protection of the patient, the hospital and the physician.

RESPONSIBILITY FOR: Maintaining a medical record, which is a complete case history or written report, pertaining to each patient. The record should include identification data, chief complaint, past medical history, family history, history of present illness, results of physical examination, and provisional diagnosis; consultations and other special reports; clinical laboratory, pathology, and x-ray findings; medical or surgical treatment, physicians' orders, progress notes, final diagnosis, condition on discharge and follow-up records; report of autopsy if performed; and nurses' graphic charts.

The department receives and reviews medical reports and refers incomplete or inadequate records to the responsible physician or department head for corrective action. It also reviews clinical records received with patients transferred from other hospitals and initiates action to obtain missing data.

The department maintains and indexes records in a number of ways. These include a patients' index, filed alphabetically by patients' names, containing name of patient and attending physician, date of admission, and file number; index of disease, filed according to the Standard Nomenclature of Diseases and Operations or by some other accepted system; index of operations, which permits study of all patients in the hospital for any specific type of operation; physicians' index, containing physician's name, file number of patient, and end results; and an index of end results which can be arranged according to such classifications as elective, emergency, and palliative.

In some hospitals, the medical records department provides analysis and technical evaluation of clinical records. The department is also assigned the function of preparing a daily census, and monthly and annual statistical reports of services to patients in order to assist the staff in evaluating and improving professional work of the hospital. In addition, it may make group studies of diseases and collect scientific data from literature for use by medical staff.

AUTHORITY: Authority for maintaining complete and accurate records must be delegated to the MEDICAL RECORDS LIBRARIAN, who reports to the ASSISTANT ADMINISTRATOR.

INTER- AND INTRA-RELATIONSHIPS: The medical records department maintains close relationships with the medical staff and the staff of the nursing service department. There is usually a standing committee of the medical staff on medical records. In addition, since the medical record has great value in legal defense to both physician and hospital, the librarian is occasionally called to present medical records in court. The library works closely with related health groups, particularly local public health units, by providing statistical information, pertinent records and reports.

STANDARDS: All records must be completed, assembled, and coded in accordance with standards of the American College of Surgeons and the Council on Medical Education and Hospitals of the American Medical Association. Except in emergencies, history, results of physical examination, laboratory findings, and provisional diagnosis should be recorded prior to an operation. The attending physician is directly responsible for accuracy and completeness of a case record even though he may not have prepared it himself. No case record can be considered complete until it has been reviewed and signed by the attending physician.

The American Association of Medical Record Librarians and the Council on Medical Education and Hospitals of the American Medical Association have

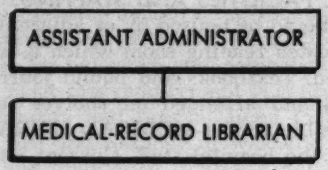
adopted a curriculum for training schools, and have established a national registry for MEDICAL RECORD LIBRARIANS.

PHYSICAL FACILITIES AND STAFFING: The medical records department should be easily accessible to the medical staff. Quarters must be large enough to provide ample storage space, work desks for physicians, residents and interns, and equipment for clerical staff.

The department should be directed by a MEDICAL RECORD LIBRARIAN who is registered by the American Association of Medical Record Librarians. The staff may range from a full complement of assistant librarians, clerical workers, and medical stenographers, to a single MEDICAL RECORD LIBRARIAN.

MEDICAL RECORDS DEPARTMENT

PROFESSIONAL



Nursing Service Department

PURPOSE: Furnish nursing care, as a part of professional treatment, for the recovery and physical and mental well-being of the patient.

RESPONSIBILITY FOR: Care of the patient. This department is responsible for a variety of functions which may be described under the headings of professional and semiprofessional, administrative, clerical, and nonprofessional. In the large hospital, the nursing department is usually divided into specialized nursing units each of which performs the following general functions.

Professional and semiprofessional: Professional nursing is concerned directly with care of the patient. Established professional procedures determine many of the functions routinely performed in this area. Other duties are performed only on written order of attending physicians and include, among other things, administering medications, performing routine tests such as pulse, temperature and respiration, dressing wounds, tending treatment devices, observing symptoms, and preparing patients for delivery or treatment by other special departments in the hospital.

Dietary functions entail responsibility for determining that patients receive only what has been prescribed and for recording information pertinent to patients with dietary problems.

The department is charged with responsibility for morale and comfort of patients, proper execution of physicians' orders, cleanliness of departmental areas, observance of all safety precautions, and knowledge of condition of the patient at all times.

Administrative: Control of organizational structure of the department involves planning and administration of training programs, maintaining time records for payroll purposes, and assigning and supervising nursing duties. Administrative functions also include responsibilities for drugs and narcotics, for maintaining stocks of equipment and material at levels and in a condition adequate for operation of nursing units, and for coordination of clinical training of student nurses with other functions of the department.

Clerical: Maintenance of records is essential to operation of all departments concerned with care of patients. The department is responsible for the nurses' section of medical records; initiating requisitions; preparing diet cards, daily floor census, and records of supplies; forwarding charges to the business office; and initiating birth and death record forms.

Nonprofessional: Bathing patients, making beds, serving meals, supervising cleaning of rooms and wards, and contributing to the physical comfort and safety of patients constitute a good part of the department's responsibilities in this area.

The special nursing units generally found in the nursing service department include medical and surgical, pediatric, orthopedic, obstetric, psychiatric and tuberculosis. In addition to the over-all responsibilities of nursing service they also carry more specific responsibilities and functions of patient care. The clinical education of student nurses is frequently a function of these special nursing units.

Medical and Surgical: Nursing care is provided in medical and surgical units in accordance with physicians' instructions and recognized techniques and procedures. While medical conditions are not easily divided into distinct categories, medical nursing is considered a specialty in that normal and abnormal reactions to symptoms of diagnosed diseases must be recognized and reported. The patient with pneumonia or a cardiac condition requires a much different type of nursing from that given the patient with anemia, diabetes, or nephritis. Surgical patients also require special pre-operative and post-operative care.

Pediatrics: This service embraces care of children under 14 years of age. Care of the newborn is usually in a separate unit located in the obstetric service. The activities of the pediatric unit are largely medical but some understanding of the unique needs, fears, and behavior of children is required. This is reflected in the type and degree of nursing care given. In illnesses with protracted convalescence, education and occupational therapy become functions of nursing service. Relationships with parents also pose special problems and responsibilities.

Orthopedics: Nurses in this unit must have a thorough knowledge of operative procedures in all types

of bone, joint, muscle, tendon, nerve, and other corrective surgery, as well as familiarity with techniques for care of patients after operation. Knowledge of skeletal and circulatory systems is involved. Special beds, splints, and frames, as well as all aspects of physical and occupational therapy, are employed in treatment and rehabilitation of patients in this department.

Obstetrics: Prenatal work, observation and comfort of patients in labor, delivery room assistance, and care of mothers after delivery, as well as nursing care of newborn, are important responsibilities of this unit. Obstetric nurses assist in education of new mothers in postnatal care and care of the newborn. Care of the newborn, particularly the premature, requires special nursing skills dictated by their unique requirements.

Tuberculosis: Tuberculosis is usually a longterm illness and special facilities are required. Nursing care for the tubercular patient must reflect understanding of effects on patients of longterm illness, specific knowledge of prevention of infection among personnel. Family and community education is also an important function of tuberculosis nursing.

Psychiatric: While most mental patients are treated in specialized hospitals, the general hospital also has recognized its responsibility and provided facilities for caring for mentally ill. Nursing care of mentally ill requires a knowledge of various behavior patterns evidenced by mental patients and how to cope with them. Techniques for dealing with all types of problem behavior must be learned, so that skilled, therapeutic care is given to such patients. Family and community education is also an important function of the psychiatric unit.

Other special units found within the nursing service department are operating room, recovery room, emergency room, and central supply.

Operating Room: This unit has primary responsibility for the maintenance of aseptic technique. It is also responsible for scheduling all operations in cooperation with surgeons, and for determining that adequate personnel and space are available. Nursing personnel assist the surgeon during operations and are part of the surgical team. Preparation for operations involves sterilization of instruments and equipment. Cleaning up after operations is also part of the unit's responsibility. This unit also may be responsible for maintaining activities of the brace shop and plaster and cast rooms.

In many hospitals, the recovery room is an adjunct responsibility of the operating room unit. Special nursing attention must be given to the patient after operation until he has completely recovered from effects of anesthesia. It has been found that this may be accomplished more effectively if the patient is kept in a special unit near the operating room.

Emergency: The hospital has a responsibility to provide emergency service on a 24-hour basis in situations requiring immediate life-saving measures. This unit is responsible for rendering such emergency care, or for making arrangements to admit the patient to the hospital or other facility. The unit performs admitting procedures; completes required records; makes reports to police, safety and health agencies; handles matters of payment and notification of relatives; and refers patients to other services within the hospital as needed. The facilities of the hospital are available to the emergency unit for diagnostic services, such as x-ray, laboratory, and operating room.

Central Supply: A description of the central supply section will be found elsewhere in this presentation although it is usually considered a part of the nursing service department.

Outpatient: While the nursing service department is not totally responsible for outpatient services, it is responsible for performing many nursing activities in this department. (See "Outpatient Department.")

AUTHORITY: At the head of the department is a DIRECTOR OF NURSING, who reports to the ADMINISTRATOR and, in accordance with over-all hospital policies, is delegated authority for providing a nursing service and educational program. Professional nursing procedures are developed in cooperation with the medical staff, but the DIRECTOR OF NURSING must retain authority for seeing that these procedures are practiced by all nursing personnel. In hospitals having a school of nursing, there will be an ASSISTANT DIRECTOR, NURSING EDUCATION, who reports to the DIRECTOR OF NURSING, or the DIRECTOR OF NURSING will function as director of the school as well as director of nursing service. (A separate departmental description of the nursing education department will be found on page 24.)

Each of the special units described earlier are headed by a nurse, supervisor, who reports to the ASSISTANT DIRECTOR, NURSING SERVICE. Nurses and auxiliary workers are assigned to each unit and are supervised by the unit SUPERVISOR who is delegated authority for accomplishing the functions of the unit.

The operating room assumes the status of an independent operating unit. Administratively, the SUPERVISOR, OPERATING ROOM, reports to the ASSISTANT DIRECTOR, NURSING SERVICE, but she must coordinate the unit's activities with the head of surgical service of the hospital, who is a physician.

Nursing personnel in the recovery room may report to the supervisor or head nurse of the recovery room, the supervisor of the operating room, or directly to the ASSISTANT DIRECTOR, NURSING SERVICE.

The obstetric unit, like each of the other nursing units, assumes the status of an independent operating unit although the NURSE, SUPERVISOR, OBSTETRICS, reports to the ASSISTANT DIRECTOR, NURSING SERVICE, and here again the activities must be coordinated with the chief of obstetrics.

Where a number of emergency services are rendered, a professional nurse supervises the department and reports to the ASSISTANT DIRECTOR, NURSING SERVICE.

INTER- AND INTRA-RELATIONSHIPS: The relationships between the nursing service department and other hospital departments are complex and too numerous to elaborate in detail.

Smooth operation of hospital services and level of patient care and treatment depends on coordinated activities of all hospital departments. The nursing service department is the hub around which many of the activities of direct patient care are centered. Relationships with other departments and the importance of each in care of patient should be mutually understood and appreciated. A definite program of conferences to work out common problems aids in developing more effective work relationships. A manual of standard techniques helps to avoid confusion in carrying out technical procedures and should be reviewed and discussed at scheduled intervals.

The nursing department has frequent contact with the medical staff, administration, patients, visitors, students, volunteers, health agencies, civic groups, schools, churches, and others. It should participate in development of administrative policies and procedures affecting nursing as well as other hospital services.

Nursing personnel have closer contact with patients over longer periods of time than any other group of hospital personnel. The nurses' attitude is vitally important to the mental and physical well-being of patients. These relationships cannot be given too much emphasis. The nursing department plays an important role in development of public and personnel relations of the hospital.

STANDARDS: Many studies have been made to improve nursing care in hospitals. The American Nurses' Association, National League of Nursing Education, and National Organization for Public Health Nursing have done much toward defining standards for the nursing profession. A joint board of directors of these three organizations has published a bulletin outlining "Principles and Policies in Relation to Subsidiary Workers in the Care of the Sick." The section on nursing of the Council on Professional Practices of the American Hospital Association, in cooperation with a committee of the National League of Nursing Education, also has prepared standards for nursing service departments as well as schools of nursing. Professional nurses must be licensed to practice their profession. Many states require the licensing of practical nursing personnel as well.

PHYSICAL FACILITIES AND STAFFING: The physical facilities of the nursing service department will depend, among other factors, upon the size and type of hospital. Certain special facilities have been suggested above. In addition to patient care facilities, the department will need an office or offices for administrative and clerical personnel, and dressing rooms for personnel.

The operating room suite, in particular, is physically set apart from all other departments and contains an office for the supervisor, workroom, sterilizing room, dressing rooms for surgeons and nurses, scrub room, operating rooms for general use, and additional rooms for different specialties as conditions may warrant.

Likewise, the obstetrics unit is physically set apart and should have facilities for labor, delivery, newborn nursery, lounge for physicians, and dressing rooms for personnel and physicians.

The ratio of nursing personnel to patients will vary considerably in different hospitals, depending on the type of patient served, variations in work load, and other factors. In addition to administrative, supervisory personnel, and professional nurses, nurses on special duty also perform professional tasks. Every hospital conducting a school for nursing personnel should have sufficient graduate supervisors and general nursing personnel to supervise student nurses and provide, at the same time, adequate nursing care for patients.

Subsidiary workers, such as NURSES' AIDES, ORDERLIES, MAIDS, clerical workers, etc., assume many of the nonprofessional responsibilities associated with care of the patient. An in-service training program should be set up for both professional and nonprofessional workers. All members of the nursing service department should be included, in order to develop and maintain *esprit de corps,* improve the technical and professional skill of the individuals, foster new ideas, and provide a means of expression for the group as a whole.

Volunteers may be used to perform many of the amenities related to caring for the patient. Volunteers are trained to perform such tasks as arranging flowers, circulating books and reading material to patients, and similar duties which make the patient's stay more pleasant. A complete description of volunteer services is taken up in a later section (see page 35).

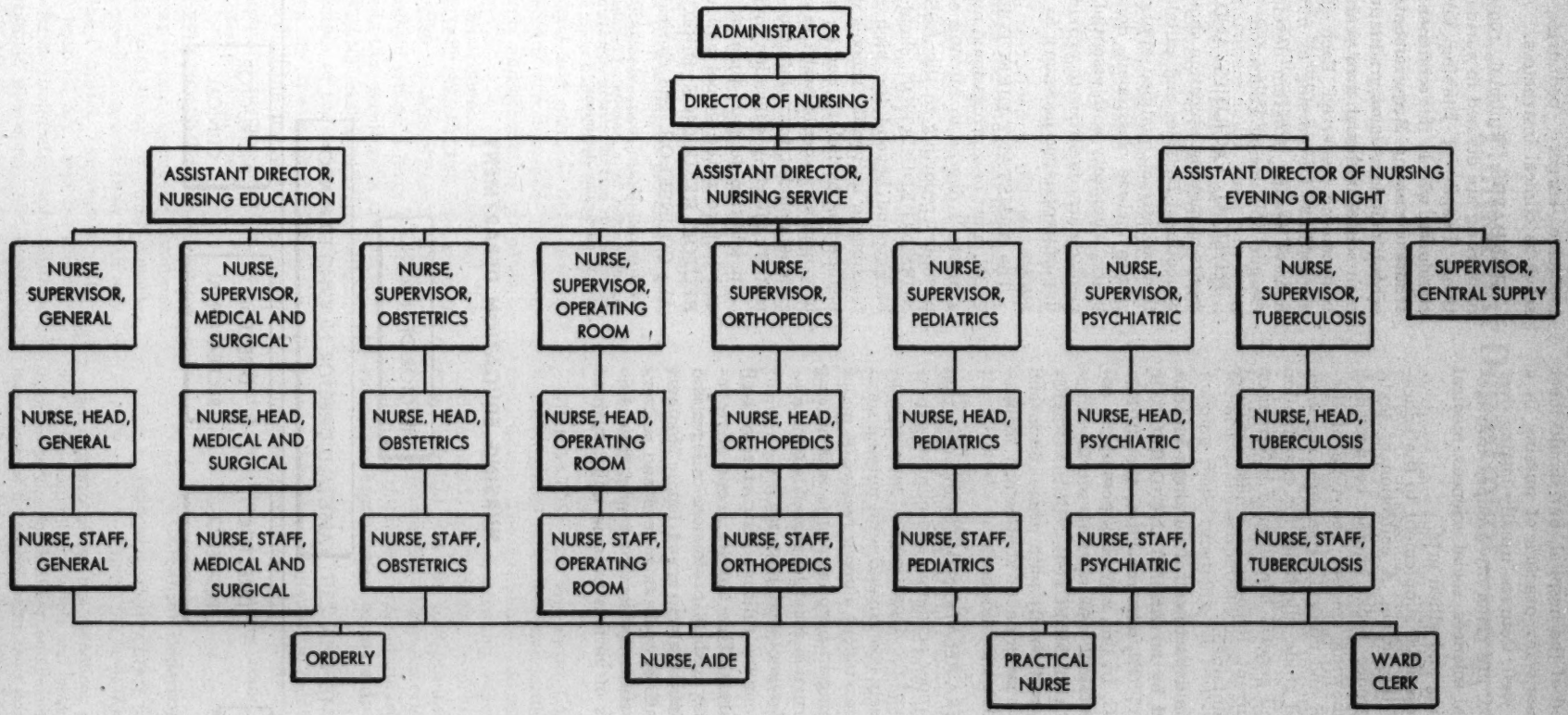
Nursing Education Department

PURPOSE: Provide for professional education of student nurses.

RESPONSIBILITY FOR: Educating nurses qualified to undertake the following duties outlined by the Committee on the Grading of Nursing Schools: Give expert bedside care and deal effectively with emergencies arising out of illness; observe and interpret physical manifestations of patients' conditions as well as social and environmental factors which may hasten or delay recovery; deal effectively with situations peculiar to certain common types of illness; apply those principles of mental hygiene which allow for the psychological factor in illness; take part in promotion of health and prevention of disease; teach measures of conserving and restoring health; cooperate with family, hospital personnel, and health and social agencies in interests of patient and community.

The curriculum of the school of nursing should not

NURSING SERVICE DEPARTMENT



only fulfill the need of the hospital, but should meet all legal requirements for practice of nursing in a particular state as well. Courses, usually lasting over a three-year period, are generally grouped into biological and physical sciences, social sciences, medical sciences, and nursing and allied arts.

A library is an essential supplement to the educational facilities of the school. A collection of texts, journals, and reference books should be provided. Student records showing amount and type of theoretical instruction and clinical experience received, class standing, final grade, eligibility for examination by state board, and general background information should be kept current. Records of school activities also should be maintained.

AUTHORITY: The department of nursing education should be directed by an ASSISTANT DIRECTOR, NURSING EDUCATION, who reports to the DIRECTOR OF NURSING. In this way it is possible to coordinate the educational and nursing service functions. The ASSISTANT DIRECTOR, NURSING EDUCATION, is concerned chiefly with organization and administration of a program of studies and maintenance of high scholastic standards.

INTER- AND INTRA-RELATIONSHIPS: In order that students receive proper academic and clinical experience, the program of the department of nursing education must be closely coordinated with nursing service activities. Since student nurses receive a major part of their training in hospital wards and nursing units, clinical instruction must be scheduled for mutual advantage of school and hospital.

The school will employ fulltime instructors as well as part-time lecturers. This implies cooperative relationships with the medical profession, colleges and universities, and specialists in many fields. Members of the medical staff, as well as college and university professors, frequently serve as part-time lecturers. Supervisors of various nursing units, such as medicine, surgery, pediatrics, and obstetrics, also serve as clinical instructors.

STANDARDS: Minimum requirements for schools of nursing are defined in various state laws. The National League of Nursing Education has national standards which it recommends for the operating school of nursing. Requirements for admission to the school include at least graduation from an accredited high school, although two years of college education is becoming preferred. Each student should possess an aptitude for nursing as indicated by a comprehensive testing program developed by the National League of Nursing Education.

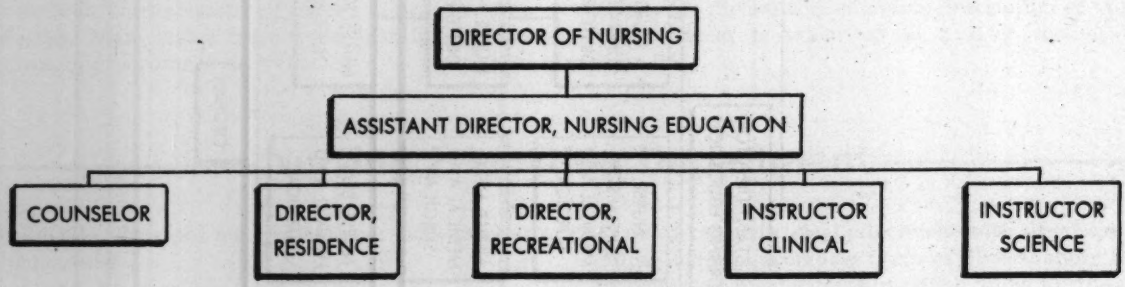
PHYSICAL FACILITIES AND STAFFING: Departments of nursing education should provide acceptable educational facilities and suitable living accommodations to attract qualified applicants. Educational facilities include classrooms, demonstration rooms, library, laboratory with essential equipment, and sufficient clinical facilities to provide the range and variety of experience necessary to instruction of student nurses.

The ASSISTANT DIRECTOR, NURSING EDUCATION, must be a professional nurse and should possess a master's degree in nursing education. The faculty members reporting to the ASSISTANT DIRECTOR, NURSING EDUCATION, should have an educational background beyond the high school level, and, for teaching in university schools of nursing,* education beyond the bachelor's degree may be required. Faculty members should assist in determination of educational policies, formulation of curriculum, and other matters affecting education and welfare of students.

In addition to part-time and fulltime instructors and lecturers, the school will usually employ a DIRECTOR, RESIDENCE; DIRECTOR, RECREATIONAL; COUNSELOR, and clerical workers.

*This description has been written to cover the school of nursing conducted by a hospital. University schools of nursing are an important part of nursing education but are outside the scope of this particular document.

NURSING EDUCATION DEPARTMENT



Outpatient Department

PURPOSE: Provide facilities for medical diagnosis and treatment for ambulatory patients, contribute to preventive health care in community, and serve in a training capacity for interns and residents.

RESPONSIBILITY FOR: Medical diagnosis and treatment in medical and surgical cases as well as in many specialties for ambulatory patients. To fulfill its responsibilities, the department must have admitting facilities, administrative organization, medical social service, clinical and nursing services, medical staff, and diagnostic services such as laboratory, x-ray, electrocardiography, and electroencephalography. In addition, the outpatient department is in a unique position to contribute to control of diseases by providing treatment while patient is still ambulant and disease is in early and more readily curable stage. Most of the functions performed in the care of inpatients are duplicated in the outpatient department.

The scope of care provided ambulatory patients is constantly increasing and, as a consequence, composition of this patient group is changing. At one time, primarily indigent or part-pay patients used outpatient facilities. As the department assumes a major role in the prevention of disease and organized community health movement, the financial character of the outpatient has changed, and in many institutions arrangements have been made for handling pay patients. Many patients are still referred to the social service department upon application for admission in order to determine their financial status and eligibility for admission. The department bears a major responsiblity for instructing its patients in prevention of diseases. Patients also must be guided during convalescence if rehabilitation is to be assured. Accurate and complete medical records must be maintained covering all social and medical data bearing on each case. Such records are necessary for group studies, medical research, and accounting purposes.

AUTHORITY: This department is headed by the DIRECTOR, OUTPATIENT SERVICES, who reports to the ADMINISTRATOR or ASSISTANT ADMINISTRATOR. In the hospital where a large number of outpatients are treated, this position is comparable to that of an ASSISTANT ADMINISTRATOR. In smaller hospitals, direction of the outpatient department may be assumed by the ADMINISTRATOR. Full authority for coordinating outpatient activities and personnel with inpatient services must be delegated to the director of this department.

INTER- AND INTRA-RELATIONSHIPS: Coordination of the many administrative and diagnostic functions of the outpatient clinic with those of other departments is imperative, possibly more so than with any other department of the hospital. The regular diagnostic facilities of the hospital are used by this department. Personnel from diagnostic and adjunct services, such as laboratory, pharmacy, and electrocardiography, may be assigned to the outpatient department for specified periods of time. Although their work will be supervised by their respective department heads, close working relationships between heads of departments and the DIRECTOR, OUTPATIENT SERVICES, are imperative.

The functions of laundry, housekeeping, maintenance, engineering and accounting are also performed in the outpatient department. Personnel performing these functions are responsible to their respective department heads although close cooperation with the outpatient department is necessary. Close relationships are also necessary with the social service department.

Physicians staffing the outpatient department are members of the regular medical staff of the hospital. This staff holds periodic conferences to review and analyze clinical work and present selected cases at the hospital's general clinical conferences.

In hospitals having schools of nursing, students are assigned to the outpatient department as part of their training in this department. Interns and residents also receive training in this department. The medical records of outpatients should be the same as those for inpatients (called unit record) and should be transferred, following the patient, from one place to the other. This involves a system for procuring and returning all outpatient records to the medical records department.

Instruction on health matters may be carried on in cooperation with community organizations, and the department should participate with local agencies regarding health education, hygiene, preventive medicine, contagious and venereal diseases, and similar subjects.

STANDARDS: The American College of Surgeons has formulated minimum standards for the outpatient department. These include recommendations as to organization, administration, facilities, personnel, medical staff, conferences, records, correlation with other hospital services, and number of patients. The outpatient committee of the American Hospital Association has published basic standards considered necessary for organization of the outpatient department.

PHYSICAL FACILITIES AND STAFFING: The outpatient department should be located in the hospital or in close proximity, to provide easy access to diagnostic facilities. A waiting room, admitting office,

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Outpatient Department

DIRECTOR, OUTPATIENT SERVICES
CLINIC TECHNICIAN

The organization of the outpatient department parallels that of the hospital as a whole and frequently draws upon the inpatient service for facilities, equipment, and personnel. For these reasons an organization chart has not been prepared.

dressing rooms for personnel and patients, and a clinical section are required by the department. Under direction of the DIRECTOR, OUTPATIENT SERVICES, nursing personnel, social workers, administrative and clerical personnel staff the department. These may be assigned on a full or part-time basis according to number of patient visits. Volunteers may perform many clerical duties. Outpatient physicians must meet the same standards applicable to other members of medical staff.

Personnel Department

PURPOSE: Coordinate needs of the institution with those of individual employees in such a way as to provide the community with efficient hospital service, and to staff the hospital with qualified, well-adjusted employees.

RESPONSIBILITY FOR: Personnel administration denotes the philosophy, motives, and methods of organizing and treating people so that they will consistently perform at the highest levels of which they are capable, while obtaining the highest possible degree of individual satisfaction.

The personnel department may assume as many functions as needed to realize a fair return on the hospital's investment in its employees. These functions will vary greatly depending on needs and size of the organization.

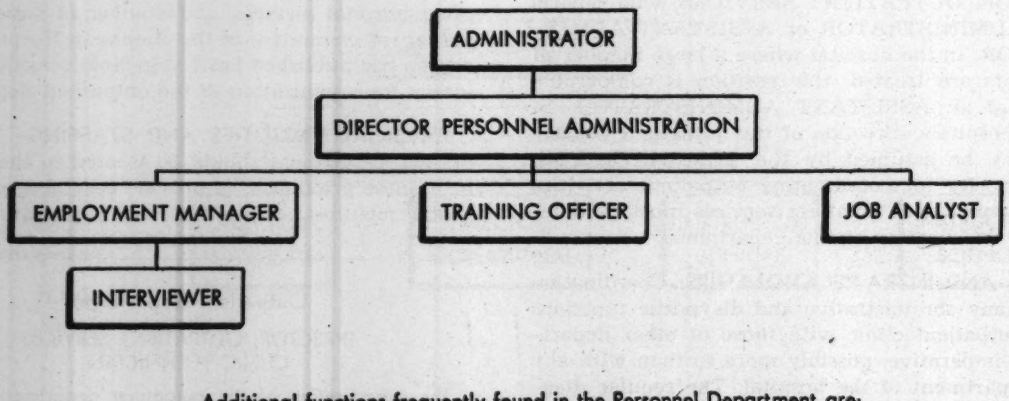
The department has responsibility, within delegated authority, for planning and administering a comprehensive personnel program, including participation in development of an over-all personnel policy. It is responsible for developing techniques and procedures for assisting line supervisors to improve the personnel aspects of their jobs. It serves as adviser to the ADMINISTRATOR on personnel problems, proposes changes in established personnel policies, and consults with and assists operating supervisors on a continuing basis. The major functions of this department may be classed as: (1) Developing sources of qualified employees, (2) attracting and recruiting competent personnel, and (3) increasing individual productivity.

Specifically, the personnel department performs some or all of following functions: Recruits and screens job applicants; inducts and orients new employees; advises on methods of training and in many instances conducts training programs; develops procedures for employees' stabilization such as absenteeism, turnover, sick leave, etc.; develops procedures for job control through job analyses and job evaluations; establishes and maintains employees' benefit program; assists in planning and establishing lines of communication; may serve as negotiator in union problems; establishes health and safety programs; advises administration on legal problems relating to employment; does research to determine causes of personnel problems; advises on hospital organization and helps establish employee budgetary controls; keeps complete personnel files on all employees; and maintains organization charts and staffing patterns.

AUTHORITY: Final authority for applying sound personnel policies rests with the ADMINISTRATOR, while the DIRECTOR, PERSONNEL ADMINISTRATION, exercises line authority only over employees in the personnel department. Personnel administration is a staff function. As such it has no direct authority over operating or line supervision. Good personnel administration is a function of every super-

PERSONNEL DEPARTMENT

MANAGEMENT STAFF FUNCTION



Additional functions frequently found in the Personnel Department are:

Employee health service
Payroll

visor, including the ADMINISTRATOR and department heads.

INTER- AND INTRA-RELATIONSHIPS: Personnel administration has become a separate department because administrative officials realize the need for specialized knowledge and careful planning to insure sound personnel relations. The personnel department should report directly to the ADMINISTRATOR. The DIRECTOR, PERSONNEL ADMINISTRATION, as a specialist, is chief adviser to the ADMINISTRATOR on all matters involving employee relations. As a staff officer, he works cooperatively with each department head to secure the maximum of efficiency and employee morale within the hospital. Theoretically, the department head should endeavor to make his job unnecessary by assisting and training every supervisor to establish high standards of employee relations.

The personnel department is a key to good public relations. Sound employee relations tend to be reflected in employee contacts with the public. Through direct contacts with other departments, job applicants, employment agencies, social agencies, schools, public officials, and many other groups and individuals, the personnel department is in a unique position to create a favorable impression of the hospital.

PHYSICAL FACILITIES AND STAFFING: The personnel offices should be easily accessible to job applicants and hospital personnel. They should be attractive to create a favorable impression on visitors. Provisions should be made for privacy in employment interviews and discussions with employees.

The personnel department is normally under the supervision of a DIRECTOR, PERSONNEL ADMINISTRATION, who possesses maturity of judgment, leadership ability, and specialized knowledge of personnel administration. No ratio has been established between numbers of employees in the personnel department and personnel comprising total organization. The needs of the institution and functions assigned to the personnel department will affect number of employees required. In general, however, it may be stated that a hospital of 160 beds which employs approximately 225 people will find need for a DIRECTOR, PERSONNEL ADMINISTRATION, on a fulltime basis. In smaller hospitals, it is usually feasible to combine personnel functions with other administrative responsibilities. Whenever such combinations are made, there should be a clear division of time and responsibility, so that none of assigned functions become subordinated to another.

Pharmacy Department

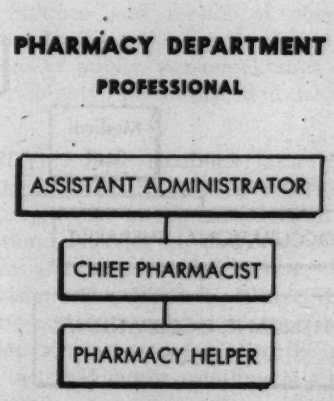
PURPOSE: Supply all prescriptions and manufactured stock drugs and solutions to both inpatient and outpatient services.

RESPONSIBILITY FOR: Routine preparation and sterilization of injectible medication and compounding of prescriptions. The pharmacy dispenses drugs, chemicals, pharmaceuticals, and narcotics on orders of a physician. It is responsible for filling and labeling all drug containers in compliance with specifications; purchase and storage of drugs, chemicals, and pharmaceutical preparations; and periodic inspection of pharmaceutical supplies in nursing units. An approved stock of antidotes is maintained. Records are kept relative to prescriptions filled; and alcohol, narcotics, and poisons dispensed. Purchase of supplies and equipment is performed either directly or through the hospital PURCHASING AGENT. In either case, the pharmacy department retains responsibility for establishing specifications of materials to be purchased.

AUTHORITY: The pharmacy is under direction of a licensed PHARMACIST, CHIEF, who reports to the ASSISTANT ADMINISTRATOR. A pharmacy committee consisting of the PHARMACIST, CHIEF, and members of the medical departments should meet periodically to determine pharmacy policy and supervise purchase and issuance of drugs, chemicals, pharmaceutical preparations, biologicals, and professional supplies. The PHARMACIST, CHIEF, is delegated authority for carrying out the functions of this department.

INTER- AND INTRA-RELATIONSHIPS: The pharmacy maintains operating relationships with most of the medical, technical, and administrative personnel of the hospital. Relationships are maintained on a day to day basis with the medical staff. This involves advising with the medical staff on the use and modes of administration of various drugs. Close working relationships are also necessary among the pharmacy, nursing and purchasing departments. Each have functions which are closely allied. Meetings to discuss common problems and activities result in more effective and efficient programs.

STANDARDS: Standards for the pharmacy department are recommended by the committee on pharmacy of the American Hospital Association and the American Pharmaceutical Association. These stand-



ards include recommendations regarding housing, personnel, pharmacy committee, maintenance of a pharmaceutical reference library, and use of approved drugs and pharmaceuticals. Legally, all pharmacies must retain a record of physicians' orders for drugs. Only drugs, chemicals, and pharmaceutical preparations of at least the quality indicated in the "United States Pharmacopeia," "National Formulary," and "New and Non-Official Remedies" should be used in treatment of patients.

PHYSICAL FACILITIES AND STAFFING: The pharmacy that serves only inpatients may be placed in any location convenient to hospital personnel. Ample shelf space is required for bulk packages. A dispensing window and suitable storage cabinets are also necessary. If the pharmacy serves outpatients as well as inpatients, it should be located so as to be easily accessible to both.

Laws in most states require that only a licensed pharmacist may compound prescriptions. He may be employed on a fulltime or part-time basis as required by the needs of the hospital. If the volume of work is insufficient to warrant employment of a pharmacist, arrangements can be made with a convenient commercial pharmacy to dispense all prescriptions. The hospital should, however, maintain a drug room from which prepared drugs are issued. Wherever necessary, as many additional pharmacists and helpers are added to the staff as are needed to insure adequate pharmacy service.

Physiatrics Department

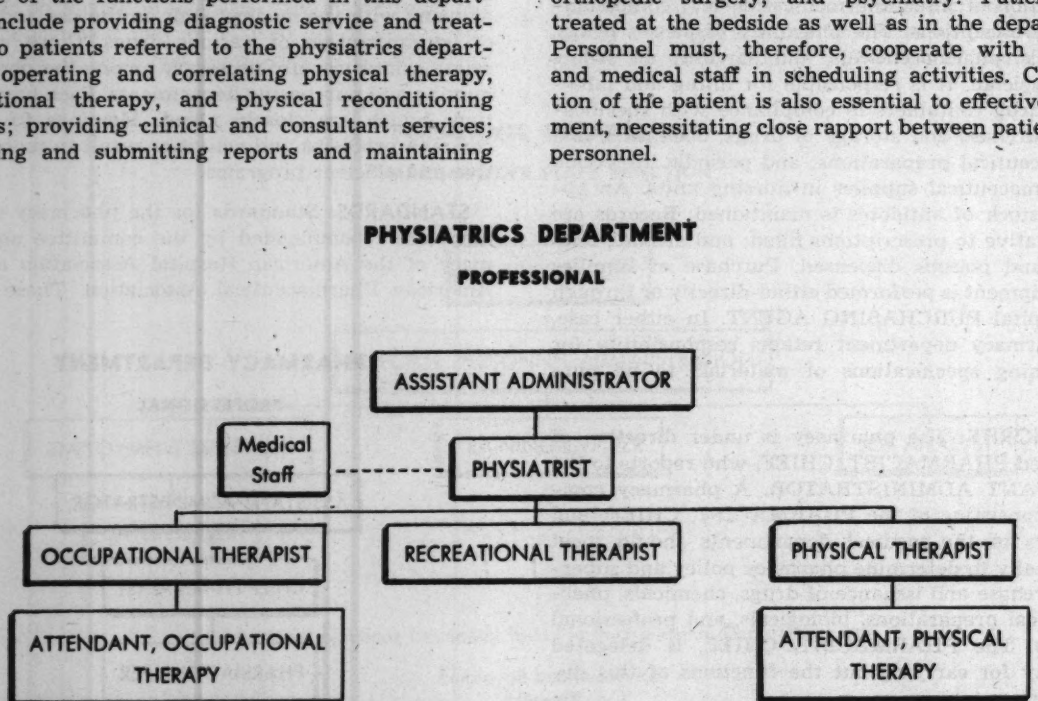
PURPOSE: Assist in recovery and rehabilitation of mental, orthopedic, traumatic, and other patients, through physical means such as mechanical devices, constructive recreational programs, and handicrafts.

RESPONSIBILITY FOR: Physical and occupational therapy. Physical therapy includes employment of therapeutic exercises and massage and utilization of effective properties of light, heat, cold, water, and electricity in treatment of disease and injury. Occupational therapy includes teaching of manual skills to stimulate mental and emotional activity on part of patients, and has been found useful in rehabilitation of chronic cases and in care of patients subject to protracted convalescence. Recreational therapy is frequently included with occupational therapy.

Some of the functions performed in this department include providing diagnostic service and treatment to patients referred to the physiatrics department; operating and correlating physical therapy, occupational therapy, and physical reconditioning sections; providing clinical and consultant services; preparing and submitting reports and maintaining records as required; and conducting in-service technical training of physical medicine service personnel.

AUTHORITY: The physiatrics department is under the direction of a physician who accepts authority for prescribing physical agents to be used. He is responsible for organization, operation, and efficiency of service and reports to the ASSISTANT ADMINISTRATOR for administrative functions and to the chief of medicine for professional services.

INTER- AND INTRA-RELATIONSHIPS: Physical medicine is a part of the total treatment of the patient and is provided to both inpatients and outpatients. As such, there must be close coordination of activities of this department with those of medicine, surgery, orthopedic surgery, and psychiatry. Patients are treated at the bedside as well as in the department. Personnel must, therefore, cooperate with nursing and medical staff in scheduling activities. Cooperation of the patient is also essential to effective treatment, necessitating close rapport between patients and personnel.



PHYSICAL FACILITIES AND STAFFING: The major portion of work of this department is with patients who are ambulatory. In planning the department, space should be provided for both treatment and dressing rooms. Rooms should provide a maximum of daylight and fresh air, and those in which electrical equipment is used should be floored with rubber tile. All apparatus should meet the approval of the Council on Physical Medicine and Rehabilitation of the American Medical Association. As a minimum requirement, the department should be provided equipment for massage, muscle training, therapeutic exercise, ultraviolet radiation, electrotherapy such as galvanic, sinusoidal, or high frequency machines, thermogenic radiation such as baking lamps, and some type of whirlpool bath or tank. The equipment required for occupational therapy depends on the various crafts utilized.

The director is a PHYSIATRIST, who holds the degree of doctor of medicine from an acceptable medical school and is preferably a diplomate of the American Congress of Physical Medicine. He may be employed either fulltime or part-time. He should have the assistance of well trained PHYSICAL and OCCUPATIONAL THERAPISTS. PHYSICAL THERAPISTS should pass the examination set up by the American Congress of Physical Medicine, thereby becoming members of the American Registry of Physical Therapy Technicians. Attendants perform many routine tasks in the physical therapy department.

Public Relations Department

PURPOSE: Interpret the policies and objectives of the hospital to the public, to foster attitudes of confidence and respect in the hospital on the part of the community, and to interpret the public opinions of the hospital to hospital authorities.

RESPONSIBILITY: The public relations department is responsible for developing a planned course of action that will keep the public informed of the benefits derived from the hospital.

The responsibilities of this department include developing public understanding and appreciation of hospital services, stimulating an active interest in and understanding of community needs and institutional resources in order that the hospital may assume its rightful place in the community, promoting improved relationships between hospital personnel and the public, cooperating with other health agencies so as to fulfill the health and welfare needs of the community, clarifying controversial health and welfare issues, stimulating voluntary contributions and public and private endowments, and interpreting hospital services and costs to the community.

To perform these functions effectively requires a planned public relations program, making use of every means of communication. Three chief channels are available: the spoken word, the written word and visual means. Probably the most effective method for building a basis for sound public relations in the community is through the spoken word of satisfied patients. There are many ways in the hospital to accomplish this end, such as giving special care to selection of personnel for admitting, information, telephone, and similar public contact positions; adjusting complaints in a sympathetic manner; promoting employee courtesy; adhering to accepted codes of ethics governing release of information; establishing routine procedures that will insure intelligent handling of patients; and developing an awareness on the part of employees, particularly nursing and medical staff, of the value of good relations with patients.

Speeches arranged by the public relations department and delivered by hospital representatives to business and service clubs, to church, school and extra-curricular groups, and to hospital visitors, as well as addresses and dramatizations for radio audiences, represent other phases of using the spoken word as a public relations tool.

Many media are also available for telling the hospital's story in writing. The newspaper offers opportunities for good written public relations in news stories about "newsworthy" events, feature articles and picture-stories, editorials, regularly published hospital news or announcement columns, and advertisements. This material may be written by the newspaper staff or by the hospital public relations department.

Regularly issued hospital bulletins sent to employees, medical staff, and others interested in the welfare of the hospital, special editions of annual reports, bulletin boards, patients' handbooks, brochures and other direct literature are additional examples of the written word in public relations use. Hospital stories may also be prepared for publication in local industrial papers, school papers and magazines.

Visual education becomes a public relations tool when posters and exhibits are displayed to the public either within the hospital itself or in other community establishments, when hospital tours are conducted for various groups, and on occasions when motion pictures or lantern slides are shown.

Other responsibilities of the public relations department may include surveying public opinion, and planning special events which utilize a combination of the techniques and means of communication. Through the effective use of all these media, the general functions of public, personnel, staff and patient education, publicity, promotion and persuasion are performed.

AUTHORITY: Public relations is a management function. The PUBLIC RELATIONS OFFICER, then, should report directly to the ADMINISTRATOR. The public relations department, however, operates in a staff capacity and has no authority over operating or line supervision. The PUBLIC RELATIONS OFFICER has line authority only over those in the public relations department working directly under him. Due to the fact that public relations is a responsibil-

ity of every member of the hospital organization, authority for sponsoring good relations with the community ultimately must rest with the ADMINISTRATOR.

INTER- AND INTRA-RELATIONSHIPS: Public relations has become a separate department because administration realizes the need for specialized knowledge and careful planning to insure public understanding of the hospital's objectives. The department plays a major role in developing the hospital's standing in the community. The PUBLIC RELATIONS OFFICER must work closely with all hospital officials. Conferences and discussions pertaining to employee relations, hospital policies and procedures, and all aspects of hospital service are part of the public relations job. Frequently, the PUBLIC RELATIONS OFFICER works closely with a special committee of the governing board. Through contact with all departments, employees, patients, visitors, the governing board, medical staff, auxiliaries, civic groups, schools, newspaper editors and writers, and many other groups and individuals, the public relations department promotes public information and understanding.

PHYSICAL FACILITIES AND STAFFING: The public relations department should be easily accessible to the executive office of the hospital.

The department is usually supervised by a PUBLIC RELATIONS OFFICER. Public relations functions, however, may be combined with other administrative responsibilities. If this is the case, there should be a clear division of time and responsibility so that neither of the assigned responsibilities become subordinated to the other. Frequently, in small hospitals, the function is handled by the administrator or a committee of the governing board. Even with a full-time PUBLIC RELATIONS OFFICER, it is advantageous to form an advisory committee of civic-minded persons familiar with public relations techniques in order to promote community interest and understanding.

Every member of the hospital's personnel and staff, as well as trustees, medical staff members and women's auxiliaries, having contact with the public is an agent for interpreting the hospital to the public and for promoting good will toward the institution.

PUBLIC RELATIONS DEPARTMENT

MANAGEMENT STAFF FUNCTION

Purchasing Department

PURPOSE: Provide centralized procurement and control of all supplies, equipment, and materials used in the hospital.

RESPONSIBILITY FOR: Determination of hospital needs and procurement of a variety of equipment and supplies.

The general functions of this department include developing specifications for common-use items; engaging in research to discover sources of improved equipment; promoting standardization and labor-saving equipment and supplies; conducting such inspections as are necessary to insure that items are not overstocked; and maintaining records.

Specifically, when a purchase order is to be placed, this department is responsible for editing orders for completeness, and for verifying orders against catalogs, previous orders, and manuals of specifications such as those established by the American Hospital Association and the National Bureau of Standards. A determination is then made of quantities to be ordered based on such information as hospital finances, market conditions, time of delivery, storage space available, anticipated rate of consumption, and availability of hospital facilities for manufacture of required items. Competitive bids are then obtained and formal purchase orders issued.

The basis for all operations of the purchasing department is the requisition initiated by individual departments. These may be either in the form of stores or purchase requisitions, depending on whether desired supplies are stocked or are to be secured through purchase. Such forms indicate date, department, quantity of each item returned for exchange, and quantity and specifications of each item desired. Requisitions are approved and signed by a responsible department authority and forwarded to stockroom or purchasing office for procurement. Supplies required before scheduled delivery dates are secured by "emergency requisitions" following similar procedures with addition of a notation stating reasons for emergency.

In some hospitals the purchasing department may receive, verify, store, and issue, as well as purchase, supplies and equipment, but this function is not recommended. Responsibility for control of storerooms should be assigned to the business department.

AUTHORITY: Since purchasing is a staff function, the purchasing department exercises no authority over operating personnel but does exert line authority over employees within the department. The PURCHASING AGENT recommends and advises department heads on quality and availability of supplies and equipment in light of special knowledge and research. He is responsible to the ASSISTANT ADMINISTRATOR or to the CONTROLLER.

INTER- AND INTRA-RELATIONSHIPS: Centralized purchasing provides advantages of economy, standardization, controlled accounting, and protection

against waste. Actual procurement in all departments need not be performed by the purchasing department, but this department should control the requisitions and purchasing procedures. A medical staff committee usually cooperates with the PURCHASING AGENT on standardization and simplification of medical supplies.

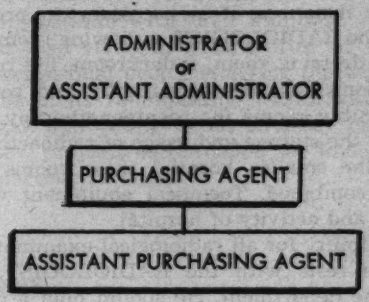
The purchasing department deals directly with most other departments of the hospital. Particularly close coordination with the business department is necessary in order to maintain effective accounting, auditing, and budgetary controls, and to maintain working contact with storerooms. In some hospitals, purchasing is a function assigned directly to the business department.

STANDARDS: The Committee on Purchasing of the American Hospital Association has published a series of specifications that may be used as a guide to more economical and effective purchasing.

PHYSICAL FACILITIES AND STAFFING: The purchasing department should be accessible to the business department of the hospital. The department is usually supervised by a PURCHASING AGENT possessing special knowledge and skills in principles and procedures of purchasing. In the small hospital, the ADMINISTRATOR may perform the purchasing functions or delegate this responsibility to the ASSISTANT ADMINISTRATOR or CONTROLLER

PURCHASING DEPARTMENT

BUSINESS AND OPERATING DIVISION



Radiology Department

PURPOSE: Provide an adjunct diagnostic and therapeutic radiology service as required in examination, care, and treatment of hospital patients.

RESPONSIBILITY FOR: Taking, processing, examining, and interpreting radiographs and fluorographs. Radiographs may be taken for diagnostic purposes or to study physiological processes. Fluoroscoping may be done to study action of internal physiological processes, localize foreign bodies, or for related medical purposes. Radiographs and fluorographs must be examined and the extent and significance of their pathology or deviation from normal interpreted. Roentgenotherapy and therapy by radium and radioactive substances may also be a responsibility of the department.

In addition to these functions, the department is responsible for planning and carrying out policies and procedures to insure protection to all hospital personnel in contact with radiation modalities; providing consultation and advice to clinicians in interpreting diagnostic roentgenological findings; planning diagnostic x-ray procedures and other pertinent matters; administering therapeutic treatment; participating in research programs; presenting films at autopsies and taking additional postmortem examinations as required to complete records; participating in hospital educational programs; and maintaining accurate and complete records.

AUTHORITY: The authority for the radiological services of the hospital rests with a RADIOLOGIST who reports to the ASSISTANT ADMINISTRATOR on administrative matters and to the chief of the medical staff on professional practices. The RADIOLOGIST is delegated authority for organization, operation and training of personnel so that an effective program is established and maintained. While standardizing agencies recommend medical supervision, administrative functions may be assigned to the X-RAY TECHNICIAN, CHIEF.

INTER- AND INTRA-RELATIONSHIPS: An effective diagnostic and therapeutic radiological program is accomplished through sound planning of the program and its supporting policies and procedures, efficient internal administration and organization, and coordination and liaison with other hospital activities. The department serves both inpatients and outpatients, as well as hospital personnel. There must be close coordination between activities of this section and all clinical activities of the hospital. Contact and cooperation with outpatient department, nursing service department and medical staff is essential. The RADIOLOGIST serves as a member of the medical staff as well as an administrative department head. This section participates in the total hospital program of patient care, research, education and community preventive health programs.

STANDARDS: The American College of Surgeons and American College of Radiology have cooperated in establishing minimum standards for hospital radiology service. To meet the minimum standards, the radiology program should have reasonably adequate space and equipment, qualified personnel, proper records and reports, and sufficient authority and personnel to carry out an acceptable program.

The American Registry of X-ray Technicians and the Council on Medical Education and Hospitals of the American Medical Association have formulated standards for technicians and it is recommended that hospitals adopt these standards which also constitute qualifications for registry by the accrediting agency.

Many hospitals conduct their own schools for training X-RAY TECHNICIANS. These schools are under direction of a RADIOLOGIST and must meet standards formulated by the Council on Medical Education of the American Medical Association, in conjunction with the American Registry of X-Ray Technicians and the American College of Radiology.

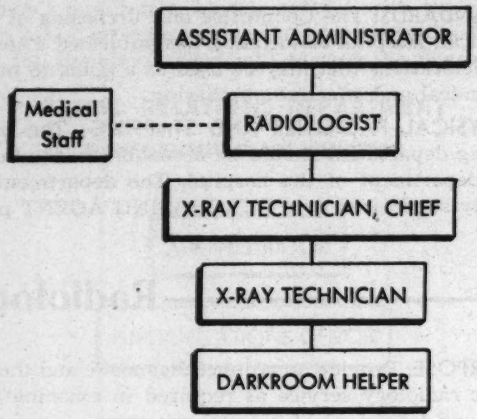
PHYSICAL FACILITIES AND STAFFING: The radiology department usually consists of therapeutic radiology, physics, and diagnostic radiology sections. All three provide specialized services to the various clinical activities of the hospital.

In most instances, it is necessary to provide an office for the RADIOLOGIST, a viewing room, a waiting room, dressing room, a darkroom, file room, one or two rooms for roentgenography and roentgenoscopy, possibly rooms for roentgenotherapy, and facilities for the storage and usage of radioactive materials. In the smaller hospital these rooms may be variously combined. Technical equipment will vary with type and activity of hospital.

Responsibility for all radiological examinations and treatments rests with the RADIOLOGIST, who is head of the department. He should hold a degree of doctor of medicine from an acceptable medical school and have qualifications in radiology acceptable to the Council on Medical Education and Hospitals of the American Medical Association. The services of a part-time RADIOLOGIST who will periodically visit the hospital and make necessary interpretations of x-ray films is the usual practice followed in the small hospital, although this does not preclude study and interpretation of films by a qualified attending physician. If a member of the medical staff with fundamental training in radiology is assigned to supervise the service, a competent RADIOLOGIST should be called upon to interpret obscure findings. X-RAY TECHNICIANS operate equipment and develop negatives under supervision of the RADIOLOGIST.

RADIOLOGY DEPARTMENT

PROFESSIONAL



Social Service Department

PURPOSE: Assist in meeting the problems of patients whose medical needs may be aggravated by social factors and who, therefore, may require social treatment based on their medical conditions and courses of treatment.

RESPONSIBILITY FOR: Contributing to diagnosis and treatment through an understanding of the social elements of the patient's life in relation to his illness. By obtaining information relative to the patient as a total individual in the social and economic environment in which he lives and works, his capacity to understand and participate in a plan of medical treatment, his obligations, and his material and personal resources, the department aids the physician in understanding and treating an illness more effectively. Similarly, by interpreting the plan of treatment to the patient and assisting in his personal affairs so as to bring relief from worry, the social service department contributes to treatment and rehabilitation. The department may be responsible for follow-up visits to homes of discharged and outpatients in order to insure continuation of treatment in an atmosphere conducive to preservation of health.

In accomplishing its responsibilities, such functions are performed as the practice of medical social case work; development of medical social service program within the hospital; and participation in development of social and health programs in the community, in educational programs for professional personnel, and in medical social research. Records must be kept on the work with the patient as a service to the patient and for educational and research purposes.

The specific function of interviewing outpatients is often assigned to the social service department. Part of this function includes certification for admission which involves determining the patient's financial eligibility, deciding whether to admit on a free or part-pay basis, and determining the need for outside assistance.

AUTHORITY: The head of the department must be a trained worker in social service. The DIRECTOR, SOCIAL SERVICE, reports to the ASSISTANT ADMINISTRATOR, MEDICAL, or to the ADMINISTRATOR. While the internal operation of the department is the responsibility of the department head, plans for treatment and procedures must be made in collaboration with the attending physician.

INTER- AND INTRA-RELATIONSHIPS: There must be a close working relationship between the social service department and outpatient department, especially where the SOCIAL WORKER, MEDICAL, is the first person to interview the patient for identifying, biographical, and sociological data.

There is continuing consultation with the medical staff in planning and developing the department's activities. The department cooperates with other social agencies and with such community resources as churches, schools, and civic groups. Contact with patients' relatives and friends is frequently necessary. Social service must also have a close working relationship with all diagnostic and therapeutic services rendered in the treatment of the patient.

STANDARDS: In 1949, a "Statement of Standards to Be Met by Medical Social Service Departments in Hospitals and Clinics" was published by the American Association of Medical Social Workers and approved by the American Hospital Association.

The American Association of Medical Social Workers has established the qualifications of training required for membership in this organization.

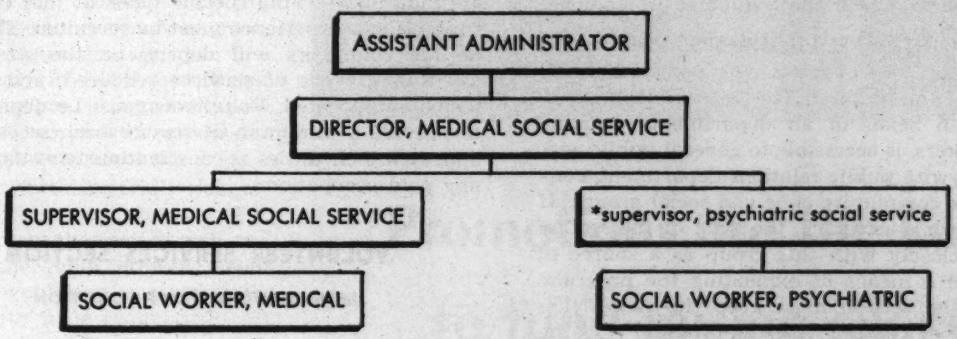
PHYSICAL FACILITIES AND STAFFING: Provision should be made for a central office for the social service department, and for such individual offices as the professional staff may require. The offices should be accessible to patients and to physicians but should afford privacy for interviews.

The DIRECTOR, SOCIAL SERVICE, should have professional education and experience in the field of medical social service work. Qualifications for the director of the department are suggested by the American Association of Medical Social Service Workers. Assistants appointed to the staff should have similar preparation. It is also well for the department to consider use of carefully selected and supervised volunteers to whom may be delegated tasks commensurate with their abilities.

There is also value in a committee of interested lay and professional people studying the work of the department in its relationships within and without the hospital, and acting in an advisory capacity to develop new projects and broaden the understanding of the department's work.

SOCIAL SERVICE DEPARTMENT

PROFESSIONAL



* Although a job description has not been prepared for supervisor, psychiatric social service, it would occupy the position designated in the organization chart in those instances where it occurred in the hospital.

Volunteer Services Section

PURPOSE: Supplement activities of the regular hospital staff in order to release technical personnel from routine duties and perform amenities which will contribute to pleasant environment and comfort of the patient and thereby help to foster favorable public relations and ease some of the pressures exerted on hospital personnel.

RESPONSIBILITY FOR: Developing, in cooperation with department heads, a program of coordinated activities where services of volunteers can be used to advantage. After initiating and conducting a survey of all hospital activities where volunteers might be used, the department is then responsible for establishing and carrying out a volunteer program that will augment and supplement the hospital program.

Volunteer services may be utilized in almost every department of the hospital, but close integration of hospital activities and volunteer functions is essential. While volunteers perform duties and provide services without pay, workers must be oriented and trained to work on a scheduled basis that fits into the hospital program.

The volunteer services section is concerned with recruiting workers, classifying them in terms of interest, experience, abilities and availability; initiating training programs; and assigning workers to duties by a process of matching workers' qualifications and job demands.

There are a number of areas within the hospital where volunteers may render valuable services. These include clerical activities in all departments, receptionist and messenger service, folding and packing surgical supplies, assistance to nurses and laboratory technicians, dietary assistance, library services, occupational and recreational therapy, sewing, refreshment shop and numerous others. The capacity of the volunteer services section to supplement and augment work of the regular hospital staff is limited only by the number and training of volunteers.

The section maintains application records of all volunteers in addition to records of performance. The section is responsible for periodic reports covering work of the organization and effectiveness of services rendered.

AUTHORITY: The section is under supervision of a DIRECTOR, VOLUNTEER SERVICES, responsible to either the ADMINISTRATOR or ASSISTANT ADMINISTRATOR, depending on the organization of the hospital. If a program involving utilization of volunteers is to have any chance for success, it must have support and approval of governing board, and fullest cooperation of administration. While the DIRECTOR, VOLUNTEER SERVICES, assigns workers to duties and is responsible for their efficiency, individual workers are supervised by those in charge of the department to which the volunteer is assigned.

INTER- AND INTRA-RELATIONSHIPS: Members of this section will come in contact with personnel in all departments of the hospital. The head of the section cooperates with heads of all departments utilizing volunteer workers, is accessible to general public and, in cooperation with public relations department, contacts numerous community civic and social groups. If there is a women's auxiliary, the head of the section should work closely with this group as a source of volunteers and a means of expanding the program. The head of the section must keep the ADMINISTRATOR in close contact with the program since he provides a source of continuing encouragement and must help prepare the regular hospital staff for use of volunteers in order to prevent friction and eliminate fears of loss of employment. It has also been found helpful to organize an advisory committee which can render considerable assistance through recommendations to head of section. Integration of volunteer activities and those of regular hospital functions requires education of regular employees as well as volunteers in order for the two groups to work together harmoniously.

Within the section itself, the DIRECTOR, VOLUNTEER SERVICES, must be continuously aware of the need for developing and maintaining the interest and cooperation of the group. Promotion to higher level jobs and rotation from routine, repetitive tasks should be the reward for excellent services. Periodic meetings are also helpful to provide opportunities for members to express themselves, meet socially, and learn of progress of service.

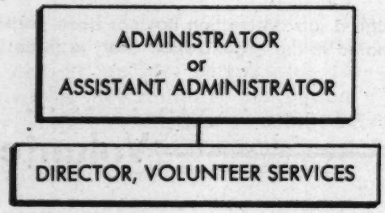
PHYSICAL FACILITIES AND STAFFING: The section should be provided with an office for the section head and dressing and locker room space for the use of volunteers.

The DIRECTOR, VOLUNTEER SERVICES, who may be a volunteer or paid employee, should have had some previous administrative experience, understand hospital routine and procedures, and be familiar with community and its resources in terms of sources of volunteers.

The staff of volunteers may be composed of individuals having a range of skills as varied as the regular hospital staff. Many of the duties require only a minimum of training and can be readily performed by a person willing to serve. For others, such as maintenance and laboratory jobs, volunteers with aptitude for learning specific types of jobs requiring training and experience must be recruited. The number of volunteers will depend on the size of the institution, types of services rendered, and number of patients treated. Volunteers must be depended on to provide a minimum of service each week and to approach their duties as conscientiously as they would any paid occupation.

VOLUNTEER SERVICES SECTION

MANAGEMENT STAFF FUNCTION



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AS THE CLIMAX of the North Shore Hospital Penny Parade, pennies collected at all schools in the hospital area were pooled. Clarabell, the TV clown, and Jinx Falkenburg McCrary are pictured receiving school collections and thanking the young donors.

Promotions are the key to fund-raising success

EDWARD E. JAMES

A YEAR AGO the trustees of the North Shore Hospital broke with tradition. For three years the group had been raising money to build a community hospital. Their approach to fund raising had been the traditional one: An analysis had been made and an organization set up to bring pressure on individuals, usually through neighbors acting as solicitors. The effort had been well supervised and in conventional terms was an unqualified success. Money had come in steadily and was still coming in.

Then came Korea. To understand what happened after that, one must know something about the section the hospital was to serve. Six communities, predominately upper-middle-class suburbs with a total population of 110,000, were involved. The county area was growing fast—faster, in fact, than any other county in the United States. On the surface it appeared easy to raise money in such a well-to-do, fast-growing section.

There were several "jokers" hidden to the casual observer. The trustees knew the section well and realized the rapid growth meant that the population was unusually young, with little ready cash. All the available money had gone into new housing. Most of the trustees worked in New York City and knew that fully 95 per cent of the wage earners were daily commuters to the big city. These were men of split interests who earned their money in New York, gave through their companies to city charities, and had little if any chance to develop a feeling for the communities they visited each evening. They knew too that the bulk of the local population had recently moved into the area from New York City and were accustomed to think of a metropolitan hospital as "their" hospital, even though that hospital in most cases was at least an hour's driving distance from the new home. A final complication was that an important group of the wage earners were of the young executive class, men who knew that if successful in their present jobs, a promotion and a transfer to another city would be forthcoming within a year or two.

Korea created a feeling of urgency within those responsible for the fund-raising campaign. A community hospital no longer was merely a needed adjunct: Now it was vital. Dependence could not be placed on metropolitan hospitals.

If public grasp of the dangerous hospital situation had kept pace with the trustees, there would have been no fund-raising problem. But wishful thinking, an obstinate belief that the emergency was not real, that the international situation would clear up in a few days, prevailed. The public thought it would be nice to have a hospital in the section, and some even agreed that a hospital was a necessity. But few felt that it was vital and came forward with cash to back their sense of urgency. The situation was desperate. Even if people had been available, there was no time to train solicitors to do the difficult selling job required under the circumstances. The obvious obstacle to fund-raising success was public indifference.

The break with tradition came

Mr. James is director of the North Shore Hospital, Great Neck, Long Island, N. Y. For another of the North Shore Hospital's fund-raising ideas, see Mr. James' article, "Ground Breaking—A Fund-Raising Potential," in HOSPITALS for July 1951.

when Tex McCrary, a young New York newspaper columnist and radio and television editor-commentator, was asked if he, as a hospital trustee, would accept personal responsibility for the fund-raising campaign. Mr. McCrary reasoned that the drive could succeed quickly if the basic pressure to give came from within the individual. "A man must not feel that he has been 'sold' the hospital. He must not just be willing to give. Our men must have a feeling of compulsion where giving to the hospital is concerned. What we must do is make the hospital the symbol of the conscience of the community." No one questioned the logic of the approach or Tex's sincerity. Few believed, however, that a promotional campaign to create pressure to give *within* each donor, rather than pressure from *without,* could succeed in raising funds for North Shore Hospital.

With the target six communities, whatever was done had to be on a grand scale. The job of creating awareness of the role of the hospital, of indirectly pointing up the urgency of creating a hospital, became a series of promotions. A promotion, whether of soap or an abstraction, is a pre-sales technique that focuses public attention on the object for which public acceptance is desired. Promotions are work savers in that a few people can do a mass sales job which, if done on an individual basis, would require a great many people. In this situation, the objective was to put across the concept that if a hospital was desired it had to be supported.

SELECTING PROMOTIONS

Promotions galore became the order of the day. An endless variety and number would have been possible, but expenses had to be held down to save money for hospital construction and to inspire confidence in the campaign management. All possible promotions were analyzed, and only a few appropriate ones were selected.

In this connection, an important policy was made: Whenever entertainment was offered for the benefit of the hospital fund, it was to be of such quality that no one could feel the price of admission had bought off his obligation to the hospital. Benefit shows could be held, but audiences were not to feel they had suffered for a worthy cause.

The first big promotion was a publicity campaign to develop awareness of the hospital drive for funds. Devices designed to reach everyone were used: Newspaper stories, at times as many as three on the front page of a single paper; radio spot announcements; posters in store windows and on bulletin boards; handbills distributed at railroad stations and busy intersections; cards attached to bumpers of parked cars; advertisements on billboards, television announcements and dramatizations; direct mail announcements; distribution of literature to children in public and church schools.

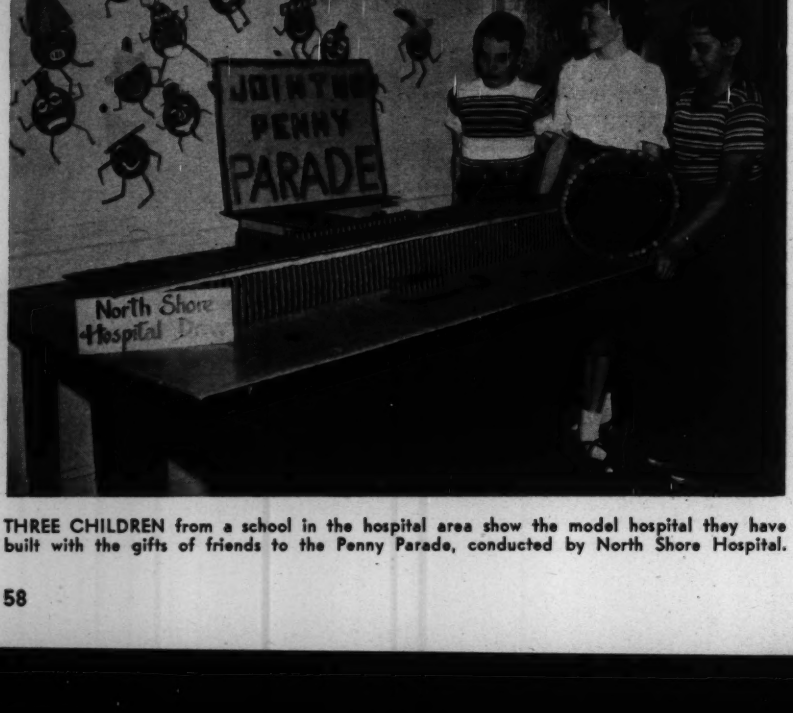
Auto caravans, lines of cars with lights blazing and horns tooting, were held simultaneously in each community. An advertising blimp flashed out a message about the hospital while circling the section at night. Paper bags bearing a printed hospital message were provided all stores for use on a certain day. Practically every publicity and saturation device known was employed in some form.

EFFECT OF PUBLICITY

The publicity campaign was deliberately overdone. It was reasoned that nothing could establish public confidence in the trustees' ability to do things right better than initial exposure to a successful campaign for which the trustees were responsible. Some within the hospital area may have lived through this promotion without learning about the hospital, but thousands of others, dozens of times each day, heard, saw, or read North Shore Hospital material. In all that material the six communities were given equal attention, to stimulate community and intercommunity consciousness in the most important element of the population, the commuter group.

The publicity campaign was eminently successful. The attention it created resulted in a congratulatory editorial in the New York *Herald-Tribune,* in which the trustees responsible for the project were commended and the hospital referred to as already "the most publicized hospital in America."

Second on the fund-raising schedule was a Star Night held at the peak of the publicity campaign. Actually an enormous benefit show, the event was staged at a near-by race track. Performers of radio, theater and movies, along with celebrities from all branches of life,



THREE CHILDREN from a school in the hospital area show the model hospital they have built with the gifts of friends to the Penny Parade, conducted by North Shore Hospital.

made brief appearances. For weeks Broadway columnists carried stories spotted by agents of the invited stars, nationally broadcast radio programs mentioned the big show, and other publicity was given the event.

AN ENTERTAINING BENEFIT

Nearly 11,000 attended despite unseasonably cold weather and enjoyed themselves so thoroughly that few left until the four-hour program ended. Use of the track and its facilities was donated; a volunteer group provided transportation for the big-name people attending and all other expenses were held at a minimum. The campaign chairman's theory was that nothing succeeds like success, and the primary objective of the event was to reinforce public confidence in the ability of the hospital group to follow through on programs it attempted. In addition to being a successful promotion, the Star Night cleared nearly $10,000.

Third promotion was the role of the hospital in the community. Human interest aspects were heavily played up. Clergymen of all faiths presented sermons about the influence on family life of the hospital. Sermonettes, 30-second spot announcements by clergymen, were broadcast on local radio stations and stressed the same point. Personal stories of how a hospital had affected their families were revealed by interested persons after hearing the clergy speak. These were written up and recorded for use throughout the fall. During this stage the danger of not having a hospital to turn to in an emergency was dramatically and forcefully brought home in terms no one, especially a young parent, could misunderstand.

The next promotion, the fourth, had more long-range than immediate significance. Called the Penny Parade, it was designed to acquaint even the youngest child in community schools with the concept of a hospital and its service. Each day pupils brought pennies to their classrooms and put them into bottles until the end of the week. At an assembly, the pennies then were poured into a single huge jar containing collections from the entire school. Classroom projects included discussion of what a hospital does, construction of a hospital building with pennies, and visiting a near-by hospital. Teachers were given source material, and throughout the Penny Parade school cooperation was magnificent.

Focal point of the Penny Parade was a procession by school children at which all school collections were pooled. Features included a song written especially for the primary grades by Singer Perry Como and a movie showing Perry singing the song with a group of school children. The song was distributed in all schools. On the back of the music were facts about the hospital prepared for adult readers. The movie was run in every theater in the vicinity the week the Penny Parade ended. An unusual promotional device, the Penny Parade attracted attention throughout the blasé metropolitan area. In all, 250,000 pennies were collected—enough to fill a light truck.

Next came a Thanksgiving Ball held only to provide a good time for all who wished to attend. The ball was a great success despite a hurricane that caused postponement for a day. Auxiliary generators had to be installed at the hall because of an area-wide power failure, and many who attended cleared fallen trees from side streets and driveways before they could use their cars. The event brought together people from the six communities and established new friendships on the basis of one common interest, the North Shore Hospital.

DISASTER SERVICE

Last of the big promotions was keyed to the stand-by nature of a hospital in times of disaster or large-scale emergency. The superb handling by the Perth Amboy (N. J.) General Hospital of South Amboy explosion victims and Woodbridge railroad accident victims* was repeatedly publicized. References were made to the possibilities of atomic attack and of more wrecks on the Long Island Railroad (used by most of the commuters).

A promotion of basically unpleasant nature, it nonetheless caused the public to face facts. By stressing the Perth Amboy General Hospital's performance the committee tried to avoid the accusation that the hospital fund was attempting to "scare" the public into giving. If a scare approach had been desired it easily could have been developed, for during 1950 alone 120 persons died and 300 were injured in near-by railroad accidents.

SOLICITATION

The value of promotions can be measured only in terms of the results they achieve. During the fall of 1950 a house-to-house solicitation was held. Organized at the last minute because of unavoidable changes in the campaign headquarters staff, the solicitation featured more enthusiasm than careful analysis of prospects. A desire to avoid entanglement with other fund drives that had been planned for many months brought the solicitation to an end sooner than otherwise would have been the case. Yet, with contacts limited in most cases to a single semi-social call by a neighbor acting as solicitor, the solicitation produced pledges totaling $750,000. Fourteen thousand families contributed, and no spectacularly large gift to distort the gift average was received.

Overhead expense for the entire promotion campaign averaged only five per cent of receipts. That the tremendous response to solicitation was the result of the promotions was indicated by the large number of checks received afterward from people who had never been contacted.

The North Shore Hospital experience proves that time-honored techniques are not necessarily the answer to all fund-raising situations. The experience of a single pioneering group cannot be regarded as conclusive, but it has pointed the way to a totally new approach to fund raising. Modified to meet other local situations, campaigns based on promotions that make people *want* to give can be as successfully employed in other parts of the country.

*For details of the role played by Perth Amboy General Hospital in the May 1950 dock explosion, see "When Disaster Struck —We Were Prepared," by Anthony W. Eckert and David T. Riddell, HOSPITALS, September 1950. For a report on the same hospital's handling of the February 1951 railroad disaster, see "Disaster Preparation—A Prayer or a Plan," by the same authors, in HOSPITALS, April 1951.

A SMALL HOSPITAL FINDS ECONOMY IN

A system of control and billing for the drug store pharmacy

W. L. MAUZY

MANY SMALL HOSPITALS must use the facilities of the local drug store's prescription department instead of hiring a fulltime pharmacist. Such hospitals must develop a workable system with the store to assure satisfactory control and billing.

Putnam County Hospital (50 beds) has solved the problem with a system that has proved successful for the last three years. This system, which transfers a large portion of the responsibilities of a hospital pharmacy department to a local drug store, requires close coordination between the personnel of the hospital and the store.

First of all, the hospital has developed a thoroughly coordinated system of purchasing, storage and distribution of those drugs kept in the stock room.

All essential standard preparations, as well as emergency drugs, are purchased by the hospital directly from wholesalers and manufacturers and are dated and stocked as they are received in the stock room. A pharmacy committee, consisting of members of the medical staff, selects the list of drugs as those most commonly used and most necessary for immediate use. This list appears in the hospital stock catalog, which is available to all doctors and nurses.

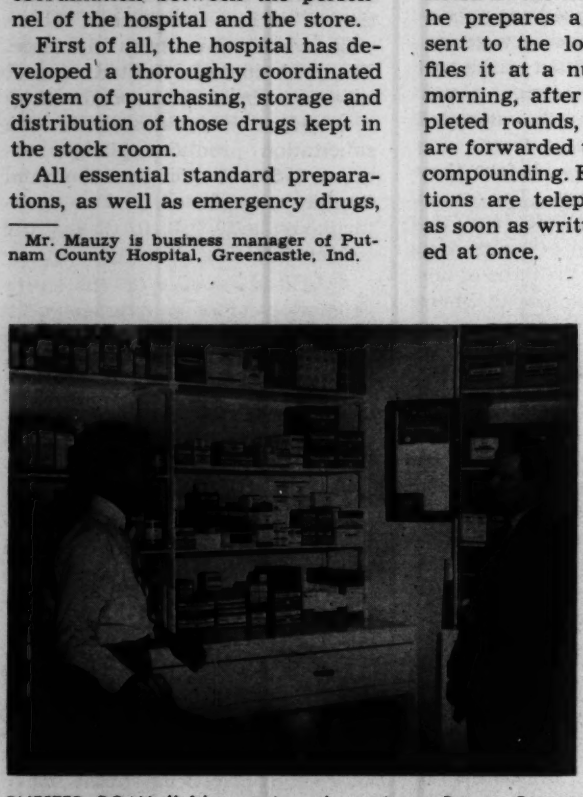
When a doctor needs a drug not listed in the hospital stock catalog, he prepares a prescription to be sent to the local drug store and files it at a nurses' station. Each morning, after doctors have completed rounds, these prescriptions are forwarded to the drug store for compounding. Emergency prescriptions are telephoned to the store as soon as written and are delivered at once.

The drug store is provided with a book of triplicate prenumbered charge slips similar to the charge slips used by the various departments of the hospital. Each patient's prescription is charged at retail price on a separate slip. The original copy of the charge slip is attached to the prescription container and forwarded to the hospital. Upon arrival, the charge slip is removed, the number checked off a charge slip control sheet set up for the drug store, and the charge for the prescription entered on the patient's ledger sheet.

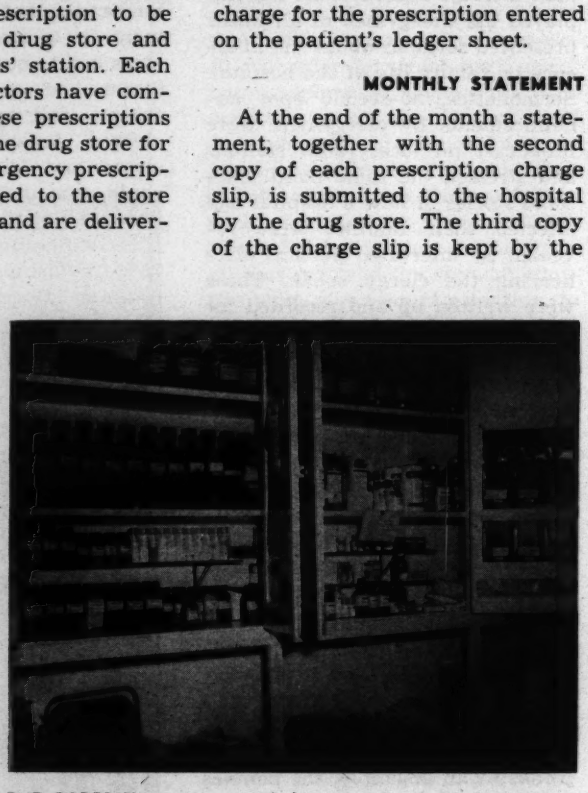
MONTHLY STATEMENT

At the end of the month a statement, together with the second copy of each prescription charge slip, is submitted to the hospital by the drug store. The third copy of the charge slip is kept by the

Mr. Mauzy is business manager of Putnam County Hospital, Greencastle, Ind.



CHESTER COAN (left), part-time pharmacist at Putnam County Hospital, discusses the drug supply in the central store room with W. L. Mauzy, business manager. A pharmacy committee, composed of staff doctors, decides which drugs are to be kept on hand.



THE ORDERLY arrangement of drugs in one of the nursing units is the work of Mr. Coan, who issues drugs from the central stock room. He labels all bottles, selected for uniformity and volume, and makes routine checks to see that drug regulations are obeyed.

store. A small discount on prescriptions is given to the hospital to cover administrative costs and bad debts.

Considering the rapid turnover of pharmaceuticals in the hospital and its effect upon inventory control, the economy of this system is apparent. It does away with the necessity of a large and varied stock of drugs needed by a private pharmacy to meet the demands of private physicians. The hospital's investment in drug inventory, therefore, is confined to several hundred frequently used pharmaceuticals, occupying a minimum of valuable space in the stock room.

PART-TIME PHARMACIST

A pharmacist furnished by the drug store once a week distributes tablets, capsules and liquids to the various nursing units from hospital stock bottles. The type and size of bottles used in the nursing units provide uniform appearance as well as proportionate volume in accordance with the average expected use of the drug. All labels for the bottles are prepared by the pharmacist to insure against carelessness or improper use.

The pharmacist advises the hospital personnel on proper storage conditions for the various drugs. He makes routine inspections of all pharmaceutical supplies on all services to make sure that regulations governing the handling of dangerous drugs are being followed. This constant vigilance also provides economies by speeding the return of outdated or slow-moving items to the manufacturer for credit.

RULES AND REGULATIONS

The pharmacist provided and posted a written set of rules and regulations pertaining to the administrative policies of the pharmaceutical service and a photostatic copy of his registration certificate. The hospital pays a nominal fee for his aid.

We believe that our system offers competent, safe and efficient pharmacy service to our patients, doctors and nurses, and that it has materially reduced the medication cost per patient day for the hospital. Since we do not have a pharmacy of our own, we believe we have found an excellent substitute.

THE TEST OF TIME

A library for patients proves its worth

AFTER 18 YEARS OF service, the patients' library of Methodist Hospital, Indianapolis, is still proving its worth.

The library was first organized as a volunteer project of the White Cross Guild. The original collection was procured through book showers. Later the guild appropriated a fund for new books and the hospital hired a librarian.

The library, which is for the staff and employees as well as for the patients, consists of about 2,200 books. We visit the floors twice each week, making an average of 115 calls daily, and circulate books and magazines to about 41 per cent of the 425 potential patrons.

Most of our literature is lightweight, simply written, and free from morbidity and vivid descriptions of horrors. To meet the need for even lighter materials, we make scrapbooks with pictures clipped from magazines.

Our hospital library tries to provide the patients with their favorite reading materials. Housewives read professional books, as well as those on interior decoration, household management, cookery, needlework and gardening. Men seem to like books on hobbies and recreation.

Sometimes we learn of a specific interest of a difficult patient. Mrs. S was always sitting in her wheelchair in the hall when we visited because her roommates annoyed her. She didn't like our books and her criticism was most disheartening. One day she asked for a copy of *McCall's* magazine. When we took her our most recent issue she said, "You know, I sew, and when I make a dress, Raymond Cooper could sell it for $75." After that, we tried to keep her supplied with the latest pattern leaflets. We suspect that her roommates also benefited.

One patient actively disbelieved in reading. He answered our first offer of library service by saying, "Sister, I don't read. When I see a guy with his nose in a book, I want to go up to him and say, 'Say, Bud, why don't you do something constructive?'"

If we succeed in giving a patient the right book on the first visit, he looks forward to the second one, and is anxious to tell us how much he enjoyed the book or of the help he got from it. One woman found the answer to a needlepoint problem in our *Good Housekeeping Needlecraft Encyclopedia*. Another patient was so inspired by Russell Dick's *Comfort Ye, My People* that he asked to read selections from it to the other patients at sunday school held each week in the hospital chapel. A young woman selected two plans for small houses from *Five Star Homes*.

When we cannot buy or make materials needed to satisfy a specific interest, we call upon local business organizations. One of our emotionally disturbed patients, who had been a farmer, seemed to dream of returning to the farm. He was unable to read, so we called a manufacturer of farm equipment and asked for any advertising materials with colored pictures of farm implements. A representative came in to explain that the company had none, but he brought the company's only catalog for the patient's use.

In addition to our books, magazines, pamphlets and scrapbooks, we have book projectors and view masters. We also have special jigsaw puzzles with a small number of large pieces for patients with arthritic hands and for older people who cannot concentrate long.

Our daily contact with patients presents new needs and suggests additional services to bring at least momentary forgetfulness. — RUTH FEDDE, *librarian of Methodist Hospital in Indianapolis.*

Administrators, department heads, key personnel—all in the hospital who write—can profit from Rudolph Flesch's research in the field of simplified, readable writing.

Are you communicating?

LYNN C. WIMMER

HOSPITAL ADMINISTRATORS, department heads and other key personnel who write informal memos, directives, bulletins and newsletters at the hospital and contribute to professional journals in the field can benefit from Rudolph Flesch's research in the area of readable writing.

Mr. Flesch's thesis — "write as you talk," he says—can be found in four of his books that are available as a membership service through the library of the American Hospital Association. These books, "The Art of Plain Talk," "The Way To Write," "The Art of Readable Writing," and his most recent, "How To Test Readability," also may be borrowed from most community libraries.

In refining a scientific formula evolved by psychologists in the early twenties for the grading and writing of children's textbooks, Mr. Flesch developed a method for achieving plain, understandable prose.

BASIC RECOMMENDATIONS

How can you "write as you talk"? Mr. Flesch makes these three basic recommendations: (1) Use simple language, quickly recognizable words; (2) use short sentences, and (3) use many personal pronouns.

Readable writing is further accomplished, Mr. Flesch believes, by avoiding irony, rhythm, rhetorical sentences, abstract words and by introducing "human interest" into prose whenever possible.

To determine how well this objective is being fulfilled, Mr. Flesch provides some yardsticks. One is based upon syllable and sentence count per 100 words and measures the "reading ease" of the writing. Another formula measures "human interest" and is based upon the number of "personal" references in sentences.

By applying Mr. Flesch's measuring formula to the writing at your hospital, you can find out how understandable it is to your readers.

AMERICAN PROSE AFFECTED

Since these readable writing formulas were published by Mr. Flesch, there has been a renaissance of interest in better communication among business firms everywhere. Hundreds of organizations carefully examine all of the writing that leaves the office under the company letterhead to make certain that it is understandable, that correspondence really communicates.

The publication of Mr. Flesch's initial work in this field of "prose engineering" also saw the mushrooming of scores of "readability experts" with little qualification. Although aspects of Mr. Flesch's thesis have been challenged, particularly by those persons and publications* sensitive to the beauty of English and resentful of the "writing down" of the language required in observing Flesch's techniques, the consensus is that he has played a tremendous role in improving the communication value of much American prose.

Mr. Wimmer is assistant director of public relations of the American Hospital Association.

*In a "Talk of the Town" item on Mr. Flesch's simplified writing, the *New Yorker* magazine wrote, "The movies long ago decided that wider communication could be achieved by a deliberate descent to a lower level and they walked proudly down until they reached the cellar. Now they are groping for a light switch, hoping to find the way out."

RUDOLPH FLESCH

In an article, "The Language of Business," *Fortune* magazine wrote, ". . . the 'plain talk' movement . . . in only four years . . . has already produced a measurable effect upon the English of business and, if it continues to thrive, it will have a profound effect not only on the English of business but on the English of advertising, journalism and literature as well."

To find out the degree of communication in the written words at your hospital, test them against the Flesch yardstick found in considerable detail in "The Art of Plain Talk" and "The Art of Readable Writing." You'll learn exactly where your writing rates in a scale between "Very Easy" and "Very Difficult." Check all hospital memos, directives, bulletins and correspondence to make sure that the writing is readable. If it isn't, change it. If it is, you'll know that you are communicating.

This article, incidentally, rates a "Very Difficult" which is par on the Flesch formula for scientific journals read by those with high school or college educations but who constitute only 24 per cent of the population.

ORIGINAL draft of the preface to the manual "Planning Your Hospital Convention" was very wordy. In final editing the wordiness was cut. The result of applying some of the Flesch formula for readability can be seen in the two illustrations on the next page.

BEFORE

THIS MANUAL has been prepared as an aid to those associations which present conventions for their members and friends in the allied hospital field. It outlines the major areas that require special attention if the convention is to be a success. Furthermore, it suggests techniques by which associations can obtain the maximum effectiveness from their meetings—for the members, visitors, guests, exhibitors and the association itself.

Presenting an association convention is no small task. It requires considerable hard work and entails an enormous amount of planning. Frequently, the success of a meeting will depend upon the extent to which details have been observed. For example, if no one assumes the responsibility for checking the microphone and it fails to work properly, the message of a dynamic guest may be lost. Vigilant supervision of details, then, is of utmost importance and, as such, is repeatedly emphasized in the following chapters of the manual.

We have tried to review every significant aspect of successful convention planning. For some hospital associations, this booklet may contain a cumulation of details of seemingly insurmountable proportions. We urge you not to be distressed by this fact. Everything in this booklet should be familiar to you. Whether or not you want to plan your own convention with comparable thoroughness depends on the size of your membership, the comprehensiveness of your program and many other things.

The secret of a successful convention lies in judicious planning. This, coupled with scrupulous supervision and fastidious attention to detail, will insure an effective meeting. Of course, you can't be blamed if the guest speaker proves incompetent or if the panel discussions bog down through the inability of its members to contribute original, stimulating thought to the subject under consideration. Such things are beyond your control. A skillfully managed convention, however, will do a lot to help you alleviate any disgruntlement that may arise from some disappointments that occur at the best-intentioned of meetings.

All conventions, large and small, are composed of certain basic elements. For example, both require speakers, a printed program, advance publicity and hotel accommodations, to name just a few of the more obvious needs. It is only in the degree and manner in which these things are done that there is any notable distinction between conventions. For that reason, there should be something of value to every state hospital association in these pages.

There are, in this manual, a substantial number of recommendations, for procedures that are expensive. For some hospital associations they may seem unduly costly. This much should be said: Ingenuity will often furnish substitute measures that will prove inexpensive and equally effective. For example, good amateur entertainment rather than professional talent or smart mimeographing rather than letterpress printing are two ways in which costs can be reduced. There are many other ways that will undoubtedly occur to you as you study this booklet.

In trying to cover every aspect of convention presentation, this manual has, of necessity, spread itself rather thin in sections. Much more could be explained about public relations, for example. It would be possible also to write at considerably greater length on the important subject of discussion techniques. There are, however, many books on these topics. The booklet has attempted merely to point out the significance of these various areas, believing that astute hospital associations will take the initiative to investigate for themselves the refinements of many of these highly specialized areas.

Remember, if you plan your convention carefully, choose your speakers discriminately, select your chairman and committee members wisely, delegate responsibility broadly, supervise every activity scrupulously, utilize available outside help extensively and promote the event ambitiously, you'll be assured of a successful meeting.

How to do these important things will be found in the following pages of this manual.

The Council on Association Relations, under whose supervision this manual was prepared, is particularly indebted to A. F. Branton, M.D., president-elect of the Tennessee Hospital Association and administrator of the Baroness Erlanger Hospital in Chattanooga, Tenn., for his thoughtful suggestions and willing assistance in the preparation of this manuscript.

This manual has been prepared to help you present your convention. It explores the major areas in which most conventions succeed or fail. It also suggests various techniques to insure the success of your convention.

AFTER

PRESENTING a hospital association convention is no small task. It requires considerable hard work. And it takes a lot of planning. Details are important, too. Little things, like checking the mike or adjusting the lights can be as important as obtaining good speakers. We've reviewed all of these important areas of convention planning in this manual and it covers a lot of ground.

All conventions, large and small, have certain things in common. Both types require speakers, for example. They both need programs, too. And both should have some kind of publicity. It's really only the extent to which these things are done that makes the difference between conventions.

If you're concerned about expenses—and who isn't?—we'll say this: Ingenuity will save you money. And there are plenty of ways to be ingenious at a convention. For instance, you can feature amateur entertainment instead of professionals. Or you can mimeograph your program instead of having it printed in a commercial shop. You'll undoubtedly think of a lot of other economies as you read this manual that you can effect at your own convention.

In trying to cover every phase of convention planning, this manual has, of necessity, spread itself rather thin in sections. Take public relations, for a good case in point. A lot more could be written about it. That's also true of discussion techniques. And the subject of printing the program. Actually, it's not possible in this manual to cover each of these topics in great detail. We tried, though, to hit all of the high points.

Briefly, the well-planned convention program requires: (1) Good speakers, (2) smart chairmen, (3) supervised events, (4) outside assistance, (5) attention to details, and (6) effective promotion.

Ways to attain these things are outlined in the following pages of this manual.

The Council on Association Relations, under whose supervision this guide was prepared, is particularly indebted to A. F. Branton, M.D., for his thoughtful suggestions and willing assistance in the preparation of the manuscript. Dr. Branton is president-elect of the Tennessee Hospital Association and administrator of the Baroness Erlanger Hospital in Chattanooga.

The manuscript was reviewed and approved by the Membership Committee of the American Hospital Association. Celeste K. Kemler, R.N., administrator, Valley View Hospital, Ada, Okla., assisted in the preparation of the manuscript.

Memorandum to disaster planners . . .

Have you thought of these?

LUCIUS W. JOHNSON, M.D.

SEVERAL ADMIRABLE articles on disaster planning and experiences have appeared in the hospital journals during the past two years.* They have told of intelligent preparation of individual hospitals for disaster, and of the success of those plans when the emergency struck.

Now we are faced with the probability of community-wide catastrophe by enemy action. Experience in several wide-spread disasters, both in peace and war, has taught me the importance of several details which have not received the attention they merit.

The old story of the man who lost his mule suggests a good approach for planning. When the neighbors asked him how he found his mule so quickly, he replied, "I just figured where I would go if I was a mule. I went there, and there he was." In planning we ask ourselves, "What would we do, if we were the enemy, to cause the greatest disruption of the community?" Then we plan for that.

What hour will the attack occur? The enemy will give careful thought to this, just as it was done at Pearl Harbor. Shelling from the sea or bombing from the air might be most effective when the greatest number of people were concentrated in offices and factories. The atom bomb, which has definite limitations, might be used to better advantage at a time when the greatest number of workers were in the streets, on their way to or from work. Study of this point will quickly bring the realization that many of the medical staff and other workers who are assigned duties in the hospital will never be able to get there. Assignment of alternates for each job merits careful study.

It is difficult to conceive of transportation problems as serious as those that will probably arise. Large numbers of vehicles will be destroyed and roads will be jammed with rubble.

Since promiscuous pollution is natural to the human animal, and since water is vital to the life of the community, the enemy or the saboteurs in our midst will not fail to plan to interrupt the supply. Provision of emergency latrines for patients and workers in the hospital should have a prominent place in planning.

Thrilling "whodunits" stress the difficulty of disposing of a single corpse. Once, in a civil community, I had 2,000 corpses to dispose of, besides the carcasses of countless domestic animals. Nobody who hasn't had it to do can imagine the herculean nature of such a task. Burial areas should be selected near the hospital, and bulldozers tagged for digging trenches. A great number of dead and dying will be brought to the hospital. Plenty of space will be needed for identifying, recording, storing and burial.

IMPORTANCE OF SCREENING

Screening of patients brought to the hospital will be most important. If this is not carefully done, the whole effort of the hospital may bog down. This essential duty should be in the hands of the elder physicians and surgeons, men of great experience, excellent judgment, and whose decisions will be respected. The lightly wounded, the hopeless cases, the hysterical and anxious relatives must be rigidly excluded, or they will clog all traffic and impede the work of all hands. Only those in urgent need should be admitted.

The screening area is where most of the ugly rumors about brutality and inefficiency in care of the patients will originate. Such rumors are an extremely effective form of sabotage, and will not be neglected by enemy agents. It suggests that public relations work should be centered here. Good relations with press and public help to reduce panic.

Experience teaches that volunteer workers are reliable for only about 48 hours. By that time the personal and family problems of the individual seem more important than the need of the public. It is well to plan to pay the prevailing wages to all workers by then.

Other details learned by experience are these: Fountain pens are always dry when disaster strikes. Trembling fingers quickly break pencil points. Crayons like those used for marking crates will last longer. The spaces provided on identification tags and other forms are too small for legible writing by any except the steadiest hands, and nobody has steady hands when working under pressure of emergency. In 50 per cent of cases, those who provide lanterns for emergency use fail to keep them filled. Matches stored for such use are too damp to strike when the time comes, or else they are broken by unsteady hands. Pocket lighters refuse to work when most needed.

While visiting hospitals in this area for counseling about their disaster plans, I have sometimes found that the medical staffs were busily planing their clinical work without including the administrator. A study of the procedures listed for existing hospitals in "Health Services and Special Weapons Defense," the official manual, will show that eight out of 10 of them are the obligations of the administrator. It cannot be too strongly emphasized that, unless the administration is well organized to mesh with the clinical department, the physicians will never have a chance to do their best work.

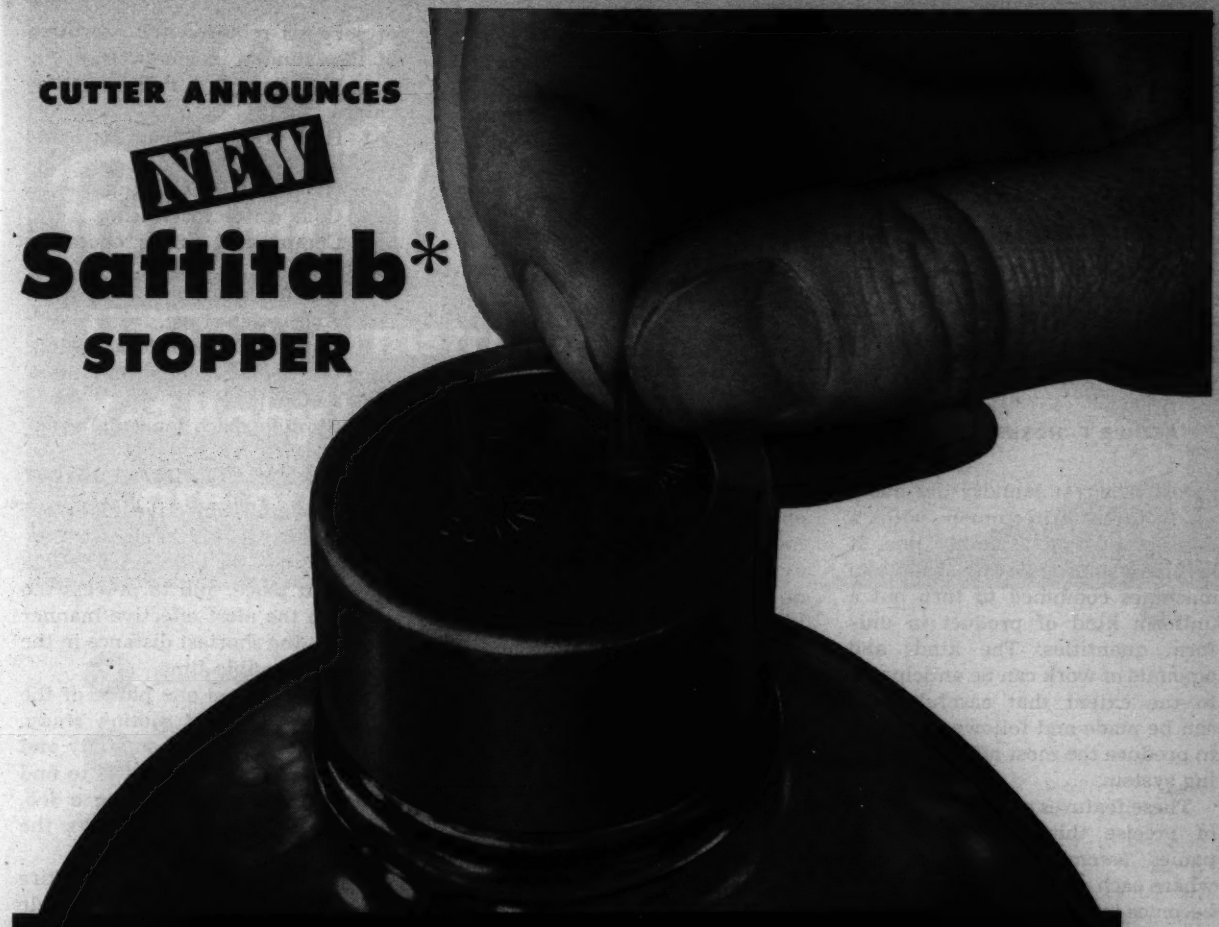
Dr. Johnson, until his retirement in November 1950, was field representative for the American College of Surgeons, San Diego.

*See "When Disaster Struck . . . We Were Prepared," HOSPITALS, September 1950, and "Disaster Preparation—A Prayer or a Plan," HOSPITALS, April 1951.

CUTTER ANNOUNCES

NEW

Saftitab* STOPPER



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Just a flick of the wrist removes the molded-in tabs at the "air" and "outlet" openings. No extra diaphragm or liner to remove.

Reduces Costs

Eliminates lost needles. There is no need for the extra needle normally used for puncturing "outlet" hole and "air" hole.

*** Exclusive on Cutter Blood Bottles**

INCREASE SAFETY
SIMPLIFY TECHNICS
CUT COSTS WITH

CUTTER Saftisystem Blood Bottles

Cutter Laboratories, Berkeley, California . . . producers of sterile, pyrogen-free Cutter Saftiflask® Solutions

*Cutter Trade Name

Improving laundry production through better plant layout

ARTHUR F. HORNICKEL

THE HOSPITAL laundry has many features in common with a mass-production assembly line. It involves labor, raw materials and machines combined to turn out a uniform kind of product in uniform quantities. The kinds and amounts of work can be anticipated to the extent that careful plans can be made and followed through to produce the most efficient working system.

These features allow for the kind of precise thinking that accompanies assembly-line production, where each motion, however small, becomes important because it is repeated so many times. Basic to the evolution of such efficiency is the placement of the various parts of the production system, or the laundry layout.

SPACE INVENTORY

Before taking up the actual layout, several questions must be asked and answered. These questions involve space—its availability and location.

Availability: Is sufficient space available? Approximately 15 square feet of laundry area is required for each hospital bed. For example, a 100-bed hospital requires about 1,500 square feet for the laundry, including space for clean and soiled linen rooms. Where rooms for clean and soiled linens are already provided, a figure of approximately 12 square feet per bed can be used.

Location: Where is the required space available? Is space available on one floor (the desirable arrangement) or over two floors? Is space available in one room, two rooms, or three rooms? Three rooms are ideal—one for soiled linens, one for actual laundry processing and one for clean linens. Will it be necessary to erect an addition or an entirely new building to provide the required space?

The site of the laundry should be as close as possible to the boiler room, water supply, electric supply and sewerage, and it should be adjacent to facilities for receiving soiled linens and delivering clean linens. The following check list can be used to determine if availability of services required for operation of the laundry is adequate:

1. Electricity for operating machines.
2. High pressure steam for heating.
3. Hot water for washing.
4. Cold water for rinsing.
5. Compressed air for operating machines.
6. Gas for heating.
7. Ample sewerage.
8. Employee facilities (toilets, showers, locker rooms and manager's office).
9. Storage space for supplies.

PLANT LAYOUT

The overall objective of layout planning is to get the right equipment, to use the right methods in the right place, and to process the work in the most effective manner through the shortest distance in the shortest possible time.

Plant layout is one phase of the broader science of *motion study*. The objective of motion study and therefore of plant layout is to find the *one best way of doing a job*. The one best way is always the method of least waste.

In a layout study, the entire plant is first considered as a single operation; the one best way then becomes the layout that requires the minimum amount of handling and transportation of the work, together with the most efficient use of available floor area.

In addition to these broad objectives, a layout study has a number of corollary objectives. A good layout should provide definite lines of travel for the work; should require a minimum amount of labor in processing, and should make easy and efficient supervision possible.

WHERE TO BEGIN

The usual approach to a layout problem is to make a scale drawing of the available floor area, make scale templates representing the existing machinery and any new equipment which is planned, and start moving the templates around on the floor plan in search of the best possible arrangement. This is certainly an important step in layout planning, but it should be preceded by a number of other steps. From the very start, three

A worthy chore

Too often, the arrangement of equipment in a hospital laundry is a thing, that, like Topsy, "just grew." With passage of time, sensible placement of parts becomes a chore that doesn't seem to be worth the trouble, especially after long standing errors have become tolerable through familiarity.

Time and time again, however, it has been demonstrated that in a repetitive-type manufacturing process, layout is the key to efficiency even though the rearrangement of heavy machinery may seem expensive.

Mr. Hornickel's article spells out in gratifying detail just how to go about improving the laundry production line, and is the second contribution that has been prepared for HOSPITALS by officers of the National Association of Institutional Laundry Managers.—THE EDITORS.

Mr. Hornickel is laundry manager and housekeeping director at Roosevelt Hospital, New York City. He also served two terms as president of the Metropolitan Institutional Laundry Managers Association of New York City and is now first vice president of the National Association of Institutional Laundry Managers.

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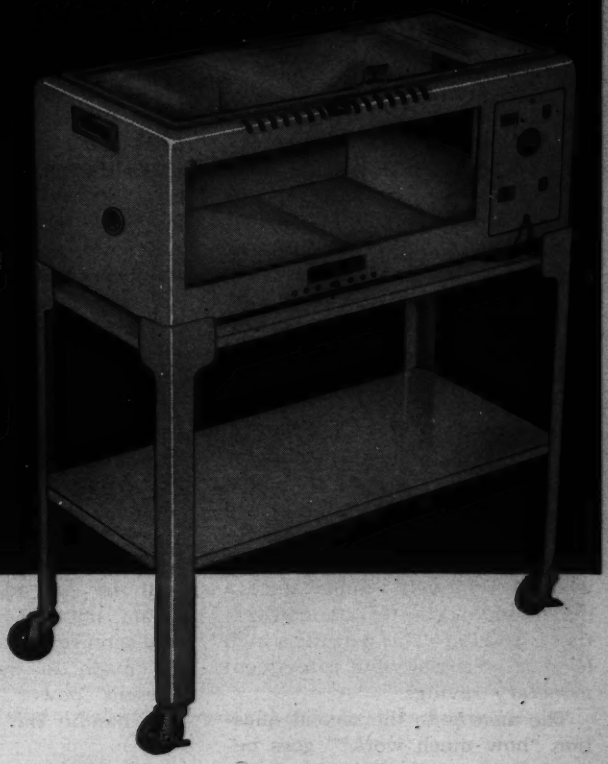

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major questions are to be answered:

1. What services or types of work to be handled?
2. How much work is to be processed?
3. How is the work to be processed? What methods will be used?

The first question, types of service, is a relatively simple problem in hospitals. The great bulk of work is standardized into one overall service, with only personal staff bundles coming under a separate category. Obviously, the types of service offered will have a direct bearing on quantities and kinds of equipment needed.

Plant layouts must provide for the most efficient use of all equipment. The plant offering only one service has distinct advantages. In it, the scheduling and routing of work is relatively simple since a maximum degree of standardization is possible. This permits a high level of efficiency with consequent monetary savings.

The answer to the second question "how much work?" goes beyond an estimate of the total volume to be expected. Once the total estimate has been made, an analysis must be carried out to determine how much work each department will handle. How much flatwork, how much tumbled work, and how much press work?

The third question "how is the work to be processed?" requires decisions on washing and finishing methods.

EQUIPMENT REQUIREMENTS

When these three questions have been answered, the next step is a study of equipment requirements for the new set-up. A schedule should be prepared showing the amount of work to be handled by each department, and, from the processing methods decided upon, the types of equipment can be selected.

From this information the size and number of pieces of equipment needed in each department can be determined. This will require data on the output or capacity of various types of equipment under consideration. Reliable data on equipment capacity can, of course, be obtained from the equipment manufacturers. In most cases, much of the existing equipment will be used in the new layout, and past and present experiences can be applied. It is usually a good idea, however, to check this data against manufacturers' specifications and also against the experiences of other plants. Once the necessary output data has been gathered, all that is necessary is to determine mathematically the number of units that will be required to handle the work in each department. It is good practice to allow sufficient equipment to handle the volume during a peak day, which is often as much as 25 per cent above average.

Some thought should be given at this point to the power plant and any changes that may be required there. If the new layout is calculated to handle more work, there will be an added demand for steam, hot and cold water, power and compressed air. A study should be made to determine whether present power plant equipment can handle the added load.

SCALE DRAWINGS

When all of the preliminary work has been completed, and not before, the actual work with layout drawings can begin. The first step is a scale drawing of the *present* layout. The most convenient scale usually is one-quarter inch to the foot. The drawing should show the available working floor areas and the location of all existing equipment.

Before starting to draw a new layout, it is wise to study the drawing of the present layout, looking for errors and possible improvements. Perhaps some of the equipment can stay where it is. A good approach is to draw flow lines for each type of work as it goes through the plant. Separate flow lines should be shown for flatwork, tumbled work, and any other classifications that are handled. When this has been done, the results should be scrutinized for cross flows, back tracking, excessively long transports, and excessive storage. Cross flows tend to produce confusion and should be kept to an absolute minimum. Back tracking also produces confusion and results in unnecessarily long transports. (Long transports, particularly of wet, heavy material, are costly.)

With the present layout thoroughly analyzed and its weaknesses and errors detected, work may be started on the new layout. The most practical approach here is to work with scale templates of the various pieces of equipment and an outline drawing of the available floor space. The templates should be cut out of heavy paper to the same scale as the drawing. Each template should be labeled to indicate the piece of equipment it represents, but it is not necessary to show all the details normally shown on a regular plan view. After the templates have been shifted around on the outline drawing into a reasonable looking layout, they should be temporarily fastened down with masking tape. The ideal to strive for in the new layout is a straight line flow, with the soiled work starting at one end and flowing in the shortest possible line to the storage space for finished work. Of course, this ideal is rarely possible to perfection, but it is important to bear in mind when compromises must be made.

Some plants are arranged so that work flow is approximately in the shape of a "U". This arrangement makes it possible for soiled work to come in and finished work to go out at the same end of the building. Without doubt, this is a good arrangement, and there may be times when the "U" flow layout is the only answer. A study of many layouts, however, indicates that the straight line type is superior, and that every effort should be made to obtain it even though conditions seem to call for the "U".

IMPORTANCE OF AISLES

Among details that should be watched carefully in working out a layout is the matter of aisles. Never underestimate their importance. There should be a sufficient number of aisles to permit the work to flow smoothly. Aisles should be straight and of ample width. Washroom aisles should be at least 10 feet wide if the washers are loaded from trucks, and at least eight feet wide if the washers are loaded from overhead hoppers. Aisles in the finishing departments should be six feet wide. An aisle should not be located next to a wall, be-

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cause such an aisle has one dead side. An aisle with machines on both sides of it will service many more machines and operators. In no case should a machine be set up so that its operator or operators work in an aisle. An operator in such a location cannot work efficiently because she is continually annoyed and interrupted by traffic in the aisle.

It is important that ample storage space be provided between departments, but it is equally important that not too much storage space be provided. Too much can be just as bad—if not worse—than not enough. A good general rule is to provide enough space for each department to hold one hour's work.

In regard to piping and maintenance, a general rule here is to place the washroom as close as possible to the power plant, but this is not inflexible. Considerations other than the cost of piping may necessitate other arrangements.

Sufficient space should be allowed around machines to permit efficient cleaning and maintenance. This should not be overdone, however, since floor space may be wasted if it is.

Each machine or department should be as close as possible to the department from which it receives its work and to the department to which its work is delivered. Also, the arrangement should be such that transportation of heavy or bulky work is kept to a minimum. Thus the flatwork ironers, which handle by far the greatest poundage, should be as close as possible to the extractors. In a multi-story plant, flatwork ironers are commonly located on the same floor as the washers and extractors. This is usually the ground floor.

LOOKING TO THE FUTURE

Some provision should be made in the layout for future expansion. This will minimize any tendency to compromise with good layout principles as new machinery is added. A caution is in order, however, since too much extra space may produce an excessive amount of walking and transporting of work, or a plant overburdened with unnecessary overhead. Allowing for future expansion is especially important where a new hospital is going up and plans include a new wing to be added at a later date.

Special consideration should be given to conveyors. They should be used wherever the investment can be justified. If used properly, conveyors can eliminate much handling and trucking, will keep the work in order, and often will save a considerable amount of floor space. They are very useful where the limitations of the building necessitate some compromise with the principles of sound layout.

FIRST BLUEPRINT

When various arrangements of the templates have been tried and the best possible layout has been worked out, this layout should be drawn up on tracing paper and blueprinted. It is a good idea to have a number of blueprints made so that the layout can be checked by as many people as possible. All suggestions and criticisms merit careful study and consideration.

After a number of people have studied the proposed layout and their suggestions have been received, it may be decided that changes should be made. If the original drawing is a pencil tracing, it is a simple matter to make these changes on the drawing and have another set of blueprints run off.

Finally, thought should be given to the sequence in which changes of equipment within the plant will be made. A time schedule should be worked out, with a limit set for the completion of the entire job. Changes in the original time schedule may be necessary, but having such a schedule will do a lot to insure that the job is completed within a reasonable period.

Many people have well-prepared plans filed in a desk drawer, waiting for the opportunity to apply them. All the plans in the world will be of no use whatsoever unless they are put into effect. Although the moving of machinery costs money immediately, machinery in the wrong place costs vast sums on the installment plan. Inefficient layout makes for inefficient people.

Check list for laundry layout

Attention to detail is the keynote of effective laundry layout. For reader convenience, the author has prepared a check list summary of the various points to be covered in preparing a good laundry layout or revising an old one to make it better.

1. Determine and define what types of services are to be handled.
2. Determine the total quantity of work that is to be handled.
3. Decide how the work is to be processed (what methods are to be used).
4. From this information and from machine capacity and output data, determine what and how much equipment is to be used and make up an equipment list.
5. Make a drawing of the present plant layout and draw in existing work flow lines.
6. Study the existing layout for possible improvements. Go as far as you can with what you have.
7. Make an outline drawing of the plant and cut out scale templates for all the equipment that is to go into the new layout.
8. Move the templates around, trying various arrangements until what seems to be the best possible layout is developed.
9. Make a tracing of this layout and have it blueprinted.
10. Have this tentative layout studied by other interested supervisors and consider carefully any suggestions which these people may offer. It is important that everyone concerned should see and comment on it.
11. Taking these suggestions into account, make a corrected tracing and a final set of blueprints.
12. Make up a time schedule for putting the plan into action.
13. Follow through, so that the new layout will become an actuality within a reasonable period.

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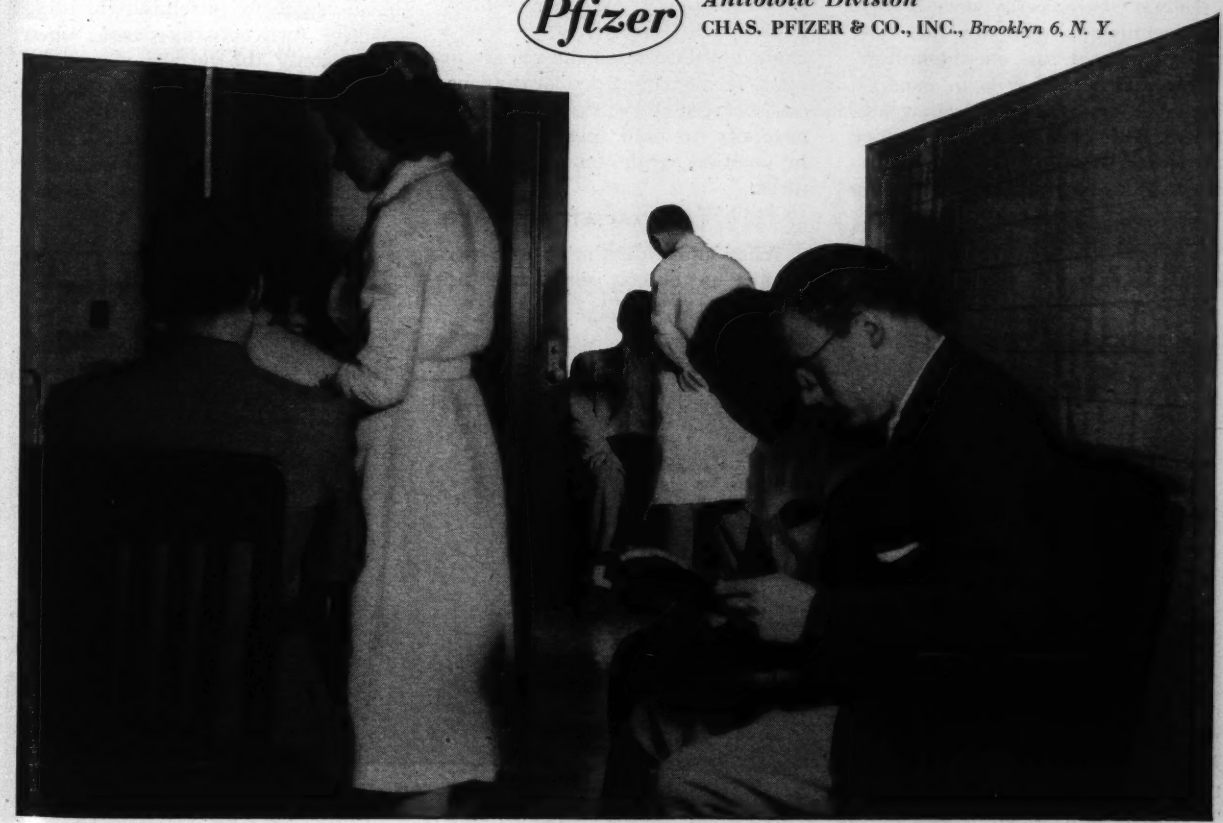


MEDICAL REVIEW

X-ray radiation study shows hazards can be controlled

ALBERT E. HEUSTIS, M.D., M.P.H., AND DONALD VAN FAROWE

MOTIVATED BY the lack of knowledge of the danger to technicians and x-ray personnel from roentgenological exposure in normal diagnostic and fluoroscopic work, the division of industrial health of the Michigan department of health made a study of the operation of these installations in the 11 state mental hospitals. This was done to determine whether personnel were being subjected to hazardous amounts of radiation, and if so, to devise control measures.

In many cases x-ray work is done by technicians who are not specially trained in roentgenology. Their main interest is in producing a diagnostic roentgenogram, giving little consideration to safety measures. Here was an opportunity to find out whether or not the greatly increased use of diagnostic x-rays makes the accumulative dose received by roentgenological personnel significant from the point of view of health.

A variety of x-ray and fluoroscopic apparatus was found in Michigan mental institutions, including machines for general and special work, machines of recent manufacture and some machines of very early manufacture having exposed x-ray tubes. Most of the machines were equipped with ray-proof apparatus, which often results in giving the technician a false sense of security. It was a chance to determine the maximum exposures encountered in diagnostic roentgenology because of the necessity to hold mental patients in position while taking the pictures.

Dr. Heustis is commissioner of the Michigan Department of Health and Mr. Van Farowe is the chief of the chemistry laboratory section, Division of Industrial Health, Michigan Department of Health.

RADIATION SCATTER

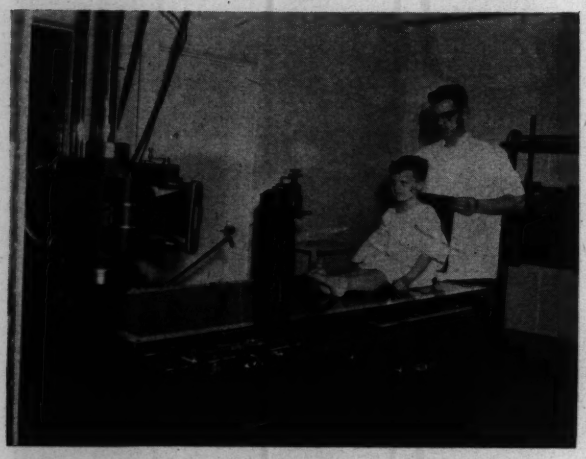
When an incident beam of x-rays strikes an object, some rays are absorbed and some pass through, but a large percentage of the rays are scattered in all directions by the electrons in the atoms which form the object in the beam. The result is similar to light in a fog. Rules for cutting down this radiation economically are hard to make because of many variable factors.

The principal sources of scattered radiation are: The patient, the table, the floor and the walls. The dosage rate and quality of this radiation vary widely with the size of the field, the angle of scattering, and the nature of the material. The intensity of the scattered rays depends upon the distance of the material and the dosage rate of the incident radiation. Since the contributing factors vary from one installation to another, uniform protection data is impossible to formulate.

X-ray radiation hazards are caused by exposure to the direct beam and to the scatter. Protection against the direct beam radiation is a necessity and this is achieved in the modern machines by shielding around the tube. Shielding materials may be applied best close to the x-ray tube, but it is more economical to purchase shielding in the form of ray-proof tubes. Then, only the hazard caused by the used beam passing through the aperture must be considered.

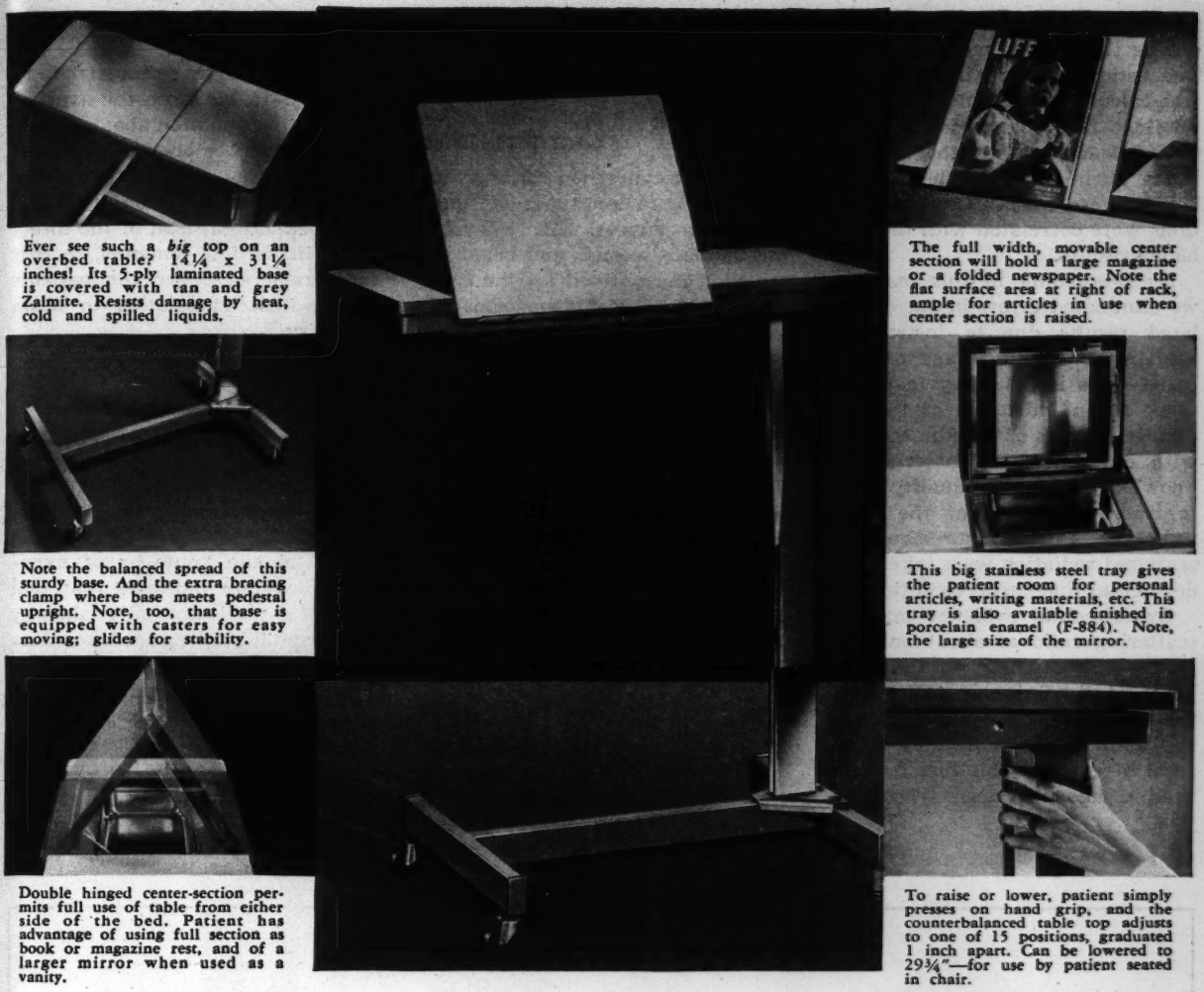
In the course of the study, film badges* were worn for a period of one month and the number and

*For further information on film badges, see "A Photographic Film Dosimeter," published by the National Bureau of Standards, U. S. Department of Commerce, Washington 25, D. C.



USING a common method of taking x-rays of children, the technician is unnecessarily exposed to radiation in holding the plate.

BY constructing a chair that will hold the plate with the film in position, the technician need not be exposed to the direct beam.



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Double hinged center-section permits full use of table from either side of the bed. Patient has advantage of using full section as book or magazine rest, and of a larger mirror when used as a vanity.

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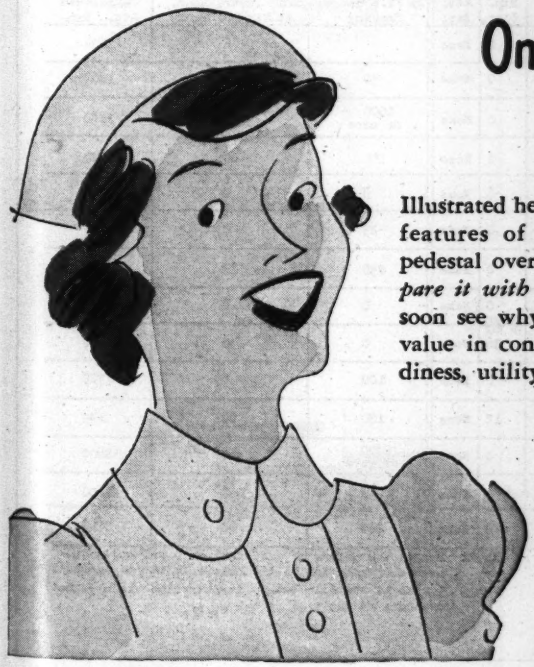

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type of all roentgenograms taken during that month were recorded. The estimated radiation exposure was calculated by multiplying the readings for each particular type of roentgenogram by the number taken during the month the film badges were worn. These calculations were correlated with the film badge results.

By proceeding in this manner, we eliminated errors in our calculated results due to instrument variations. An advantage of film badge tests is that they may also serve as an indication of the ray quality in parts of the film covered with different filter materials. A knowledge of the ray quality helps to trace the origin of the stray radiation. Our measurements of scattered radiation were taken under actual diagnostic conditions.

Experimental evidence sets the scattering ratio at about one per cent of the intensity of the main beam at a point one meter from the patient and at right angles to the beam. The scatter is a softer form of energy. This fact may be used in the shield design. The saving is not great, however, below 200 kilovolts, the range encountered in most hospital diagnostic work.

X-RAY INTENSITIES

We were concerned mainly with the most common types of diagnostic procedures. The kilovolts, milliampere seconds and beam intensities encountered for the common types of roentgenograms involved were as follows:

1. Chest x-rays: 60-70 KV at 10-15 MAS, with an average direct beam intensity used of 22 mr. at a distance of 72 inches.

2. Skull diagnostic x-rays: 60-70 KV at 75-150 MAS with an average direct beam reading of 1.8 r. at 36 inches distance.

3. Spinal x-rays—(a) AP lumbar spine: 60-68 KV and 100-150 MAS with an average beam intensity of 3 r. and (b) lateral lumbar spine: 72-84 KV at 192-400 MAS with an average direct beam intensity of 6 r.

4. Fluoroscopic settings: 65 to 78 KV, 5-15 MA with the average time for examination about 30 seconds of machine operation. No direct beam reading was taken because patients lying on the table absorbed a great deal of the direct beam in varying amounts, so that measurements above the patients meant little in relation to beam intensity.

CHART shows results of the study conducted to determine amounts of radiation operators received. The duties of the attendant are limited to holding the patient.

EXPLANATION OF CHART

The accompanying chart shows that the roentgenograms taken at the hospitals over a month's period are classified into four groups: Chest, spine, skull, and miscellaneous.

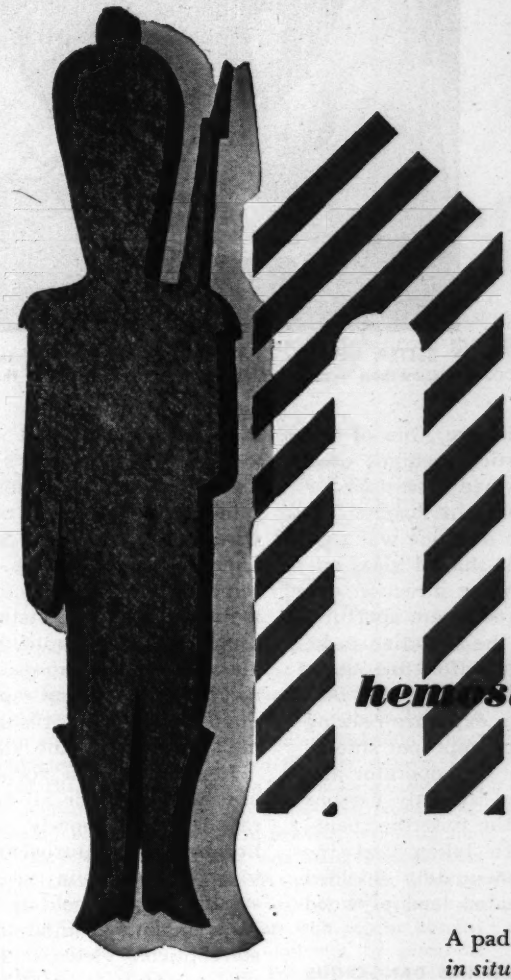
"O" in the "number of exposures" column indicates that that type of x-ray is normally taken by the hospital but was not taken during the month studied. "None" indicates that the hospital did not perform that type of x-ray or did not use an attendant. The duties of the attendant in the x-ray room are confined to holding patients.

ONE MONTH'S EXPOSURE[1]
(In Milliroentgens)

Hospital	Chest			Spine			Skull			Misc.			Act. Oper. Exp. By Film Badge Reading	Cal. Oper. Exp. From Instr. Read. At Time of Study	Calculated Att. Exp.
	No. of Exp.	Exp. Oper.	Att. Exp.	No. of Exp.	Exp. Oper.	Att. Exp.	No. of Exp.	Exp. Oper.	Att. Exp.	No. of Exp.	Exp. Oper.	Att. Exp.			
A[2]	61	0	854	6	0	174	32	256	576	36	0	None		256	1604
A[3]	61	0	854	6	0	174	32	64	576	36	0	None	50	64	1604
B[4]	46	0	1380	12	60	300	0	0	0	34	0	None	1000 or more	60	1680
B	46	0	1380	12	60	300	0	0	0	34	0	None	100	60	1680
C	56	0	1758	36	0	1908	0	0	0	39	0	None	0	0	3666
D	152	0	912	16	0	None	0	0	0	75	0	None	25	0	912
E	101	0	1742	16	256	None	42	56	None	161	0	None	250	312	1742
F	12	0	180	None	None	None	None	None	None	0	0	None	0	0	180
G	46	0	600	2	0	None	0	0	0	36	36	None	0	36	600
H	140	0	2800	48	0	4800	36	0	189	136	0	None	100	0	7789
I	9	0	120	12	48	24	None	None	None	8	12	None	180	60	144
J[4]	108	0	600	18	360	18000	6	200	2000	46	0	None	2000 or more	560[5]	18600
J	108	0	600	18	360	18000	6	200	2000	46	0	None	240	560[5]	18600
K	200	0	7280	9	0	90	35	0	870	59	0	None	200	0	8240

1 - Present maximum allowable exposure: 1200 milliroentgens per month.
2 - The calculated exposure at previous position of controls to skull machine.
3 - Exposure at recommended position. Film badge was worn under these conditions.
4 - Operator was unnecessarily exposed. Maximum reading on film badge: 1000 mr. 2000 mr. Results of second study below.
5 - Two operators.

NOTE: Due to the number of personnal involved and their method of rotation in the hospital, it was impractical for us to use film badges to determine the attendant's exposure at the time of the study.



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POOR technique in holding a patient in position. The technician is exposed to the scatter ray which angles off at 90° to the beam.

A BETTER technique is to hold the patient at head and foot. This method results in less radiation exposure to the technician.

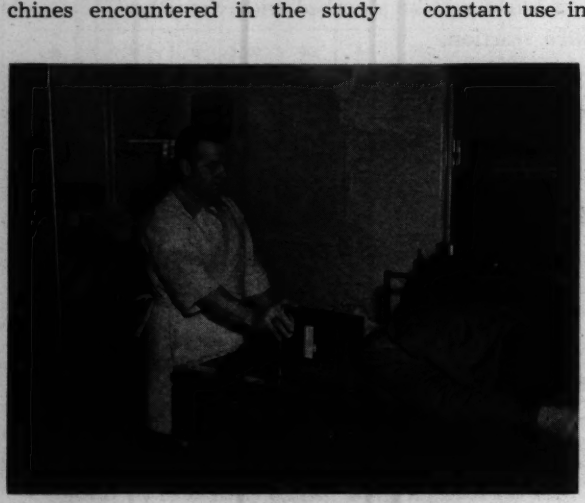
Due to the work load, some of the hospitals employed two technicians. The duties of the technicians included operation of the x-ray machine, film development, and keeping of records. The chart designates these technicians as "operators," and as such, their dosage calculation was the result of the time they were operating the machine only and did not include the stray radiation that they may have received while they were performing other duties in the x-ray room. The latter, of course, would be included in the film badge exposures. It is evident that in the hospitals employing one operator, the dosage would be absorbed by him. In the hospital employing two operators, the dosage would be split between them.

As previously stated, x-ray machines encountered in the study varied widely in age. One of the general diagnostic machines used for chest x-rays had been used for more than 30 years (in hospital F). The tube in this machine was suspended in a bell-shaped glass enclosure, open in the direction opposite to the direct beam aperture. Here we found the radiation to be 250 milliroentgens for five chest exposures five feet from the machines. This high exposure reading was the result of improper shielding of the tube. The operator and the patient were the only persons in the room at the time the roentgenograms were taken and the operator was adequately shielded behind a laminated lead plywood screen.

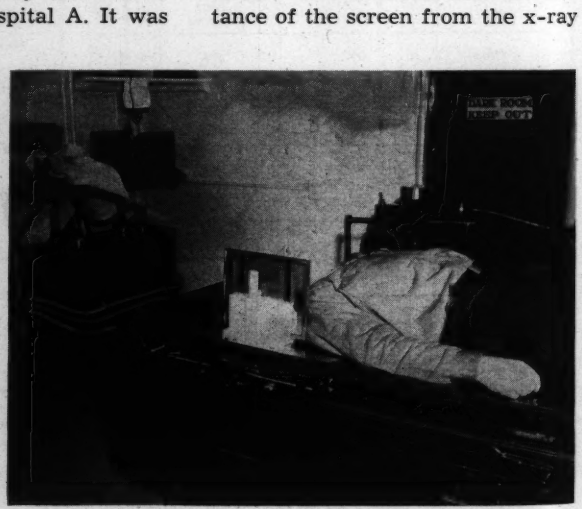
FAULTY REPAIRS DANGEROUS

A 1922 model x-ray unit was in constant use in hospital A. It was used for chest, skull and spine x-rays. The operator's exposure for one AP and one lateral lumbar spine was 70 mr. In conjunction with this machine, a fluoroscopic unit was used having about the same date of manufacture as the x-ray unit. In this installation we found that the protective leaded glass back of the fluoroscopic screen had been broken and replaced with plain plate glass resulting in a high exposure to the viewer.

In hospital I, a portable x-ray unit was used for all types of x-rays. An improperly constructed home-made fluorescent screen viewer was also in use at this institution. It was held up to the eyes in a manner similar to the old stereopticon viewers. The screen was approximately 16 x 16 inches in size. It was found that the distance of the screen from the x-ray



IN taking lateral skull plates, the technician is using an improper technique and is needlessly exposing himself to radiation.



A SIMPLE holding device can be constructed for taking lateral plates. Technician need not receive any exposure in this instance.

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Tests by eminent medical research authorities have proved that Dial's antiseptic agent gets the skin amazingly clean of bacteria ... bacteria that often aggravate and spread pimples, surface blemishes, etc. In fact, Dial, used regularly, has a cumulative effect—protection actually increases with repeated use. This is why more and more hospitals, as well as doctors and nurses, are changing over to Dial Soap. They get that important extra protection, and they like Dial's extra mildness and fragrance, too! And Dial costs no more—lasts longer!

For surgical scrub-up many hospitals use Formula No. 99. This 20% liquid hand soap contains 5% hexachlorophene, based on soap content. Scientific tests have proven that the surgeon who scrubs his hands regularly with a soap containing hexachlorophene removes, in only six minutes, one hundred times more bacteria than does one using the conventional twenty-minute scrub-up with regulat hospital soaps, followed by germicidal rinse. Formula No. 99 Liquid Soap is available in 5-, 30- and 55-gallon steel drums.

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ILLUSTRATION of poor technique in the use of a skull x-ray machine. Controls are incorrectly located in the high scatter area.

WITH the controls moved slightly to one side, the technician stands farther away and need not be exposed to as much radiation.

tube was determined only by the viewer which in most cases resulted in a direct beam exposure having a field size greater than the area of the screen itself.

With the exception of the installation at hospital G, which was similar to the installation at hospital A, the remainder of the units were of recent design. Hospital J had a recent installation but the controls were found to be too close to the diagnostic table with no protection for the operator except the distance factor. This lack of protection contributed partly to the operator's high exposure as can be seen from the chart.

ELECTRICAL HAZARDS

In addition to the possible radiation hazard, an electrical hazard may also be present. The voltages used to energize x-ray tubes are highly dangerous, and the best assurance of safety is the enclosure of the high voltage parts in a shockproof container. Most x-ray generators for diagnostic work are of shockproof construction, but where the design is such that high voltage conductors are exposed, operators should keep at a liberal distance from them, and should guard against the possibility of spark-over to other conductors with which a person may be in contact.

The most dangerous situation is to permit the body to form a part of the high voltage circuit, either across the tube terminals, or between a high potential lead, a low potential lead, or grounded conductor. Although high potential circuits do not extend into the processing room, low potential electrical outlets and fixtures may present a hazard under some circumstances. As a safeguard, the exposed portions of switches, plug outlets, lamp sockets, and the like should be composed of insulating material. No electrical device should be touched with wet hands.

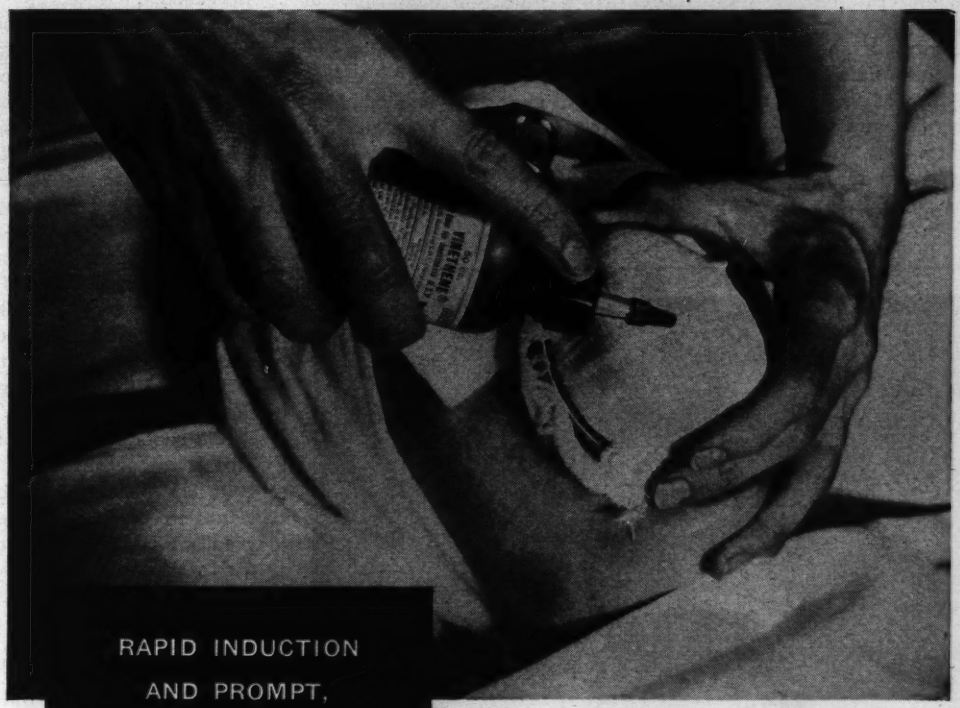
GAS HAZARDS

Despite some concern about the ozone and oxides of nitrogen concentrations in diagnostic x-ray rooms, in only two of the oldest installations did we detect the odor of ozone. In our opinion, diagnostic machines are operated for too short a period to produce ozone and oxides of nitrogen in significant quantities.

From this study came the fact that most roentgenological hazards can be controlled if the following points are noted and used to best advantage:

FLUOROSCOPIC examinations, a routine procedure in many hospitals, is very often the source of high exposure to the technician.

PROPER technique in fluoroscopic examinations involves the use of lead gloves and lead apron which should be worn as illustrated.



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1. A hazardous radiation exposure existed in some of our mental hospitals, and similar exposures of this degree may exist in many hospitals throughout the United States.

2. The most important factor in eliminating this hazard is the planned training of technicians in proper techniques and in the dangers of radiation.

3. Outmoded and improperly designed x-ray machines are only one factor in x-ray radiation exposure in roentgenological personnel. Other factors include the volume of roentgenograms, type of roentgenograms, and techniques of the operators. These latter factors have no relation to improper design of x-ray machines, and, therefore, high exposure can also be found in the newer type of machines as we have discovered by this study.

4. Large x-ray rooms are safer than small ones, since the amount and concentration of scatter is reduced and the distance between the operator and the tube may be increased.

5. The proper enclosure of the x-ray tube is important.

6. The use of proper cones is important. Not only is proper coning of the beam desirable to reduce the amount of scatter and the attendant's exposure, but also to reduce to as small as possible the area of the patient's exposure.

7. Filtration of the beam through one mm. of aluminum is important. It has been found that 300 r. is the erythema dose for unfiltered x-rays while 400 r. is the erythema dose of x-rays filtered through one mm. of aluminum.

8. Proper shielding of the operator is important.

9. The necessity for holding patients in position for x-ray work creates a definite exposure problem for attendants and operators. A similar problem may exist in other than mental hospitals and clinics when x-rays are taken of unmanageable patients such as babies, small children, and older individuals with senile changes.

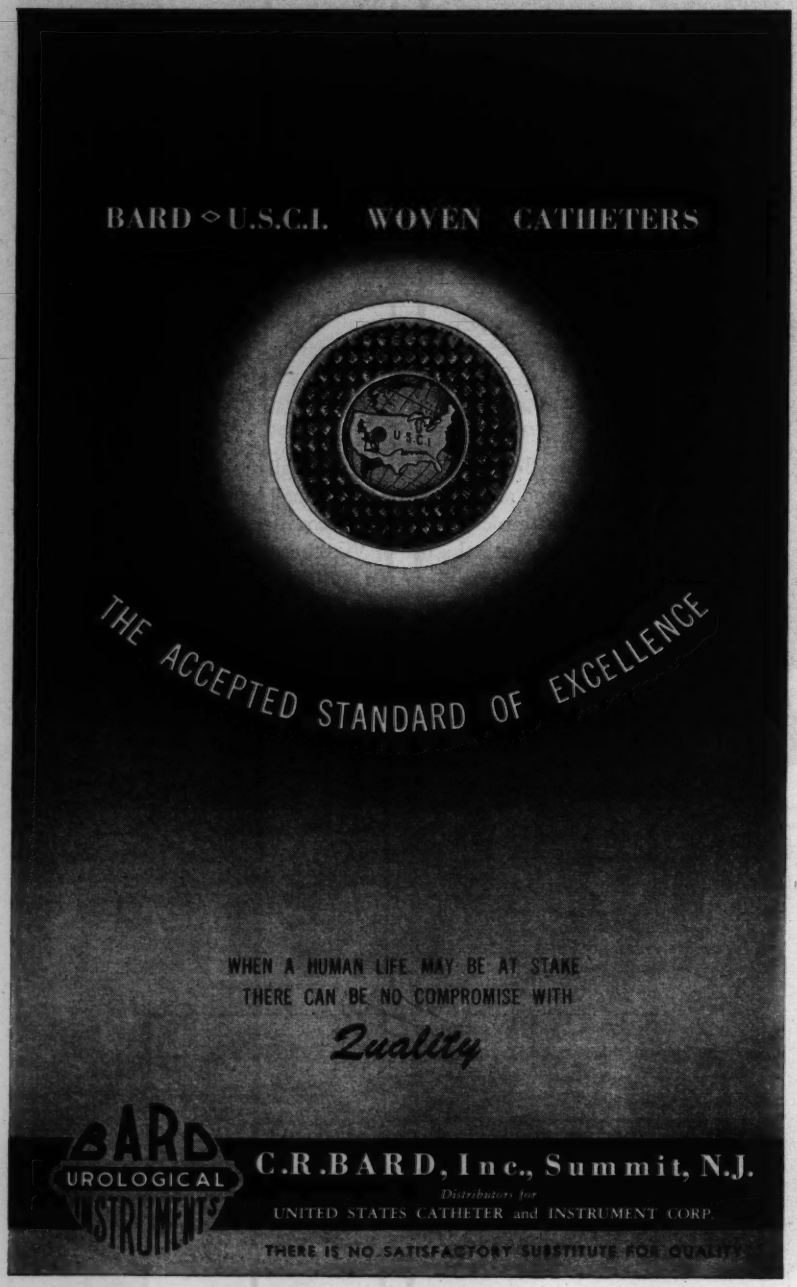
10. Planned rotation of attendants should be carried out if patients must be held.

11. Every hospital should have several pairs of lead gloves and several lead aprons. These articles should be used.

12. It was found that simple changes often made a considerable reduction in radiation exposure. In some cases, as is shown by this study, the radiation was reduced to one-eighth of the original exposure by simply moving the controls slightly or changing the position of the operator by a few feet. Roentgenological personnel should be conscious of these possible chances for improvement.

13. A periodic check should be made on stray radiation received by x-ray personnel. This may be accomplished by pocket ionization chambers in conjunction with film badges calibrated at about 85 KV energy range.

14. Every effort should be made to reduce the radiation exposure to as low a figure as possible regardless of whether or not the present exposure is below the maximum allowable radiation limits.



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A variety of readings for the administrator and his staff

RECENT ADDITIONS to the library cover a wide range of subjects, all pertinent to the hospital field. The new books reviewed on this page are of interest to the administrator, members of the nursing staff, and the patient.

A nurse who made history

MILITANT ANGEL. Harriet B. Koch. New York, Macmillan, 1951. 167 p. $3.

ANNIE W. GOODRICH, HER JOURNEY TO YALE. Esther A. Werminghaus. New York, Macmillan, 1950. 104 p. $1.50.

IT IS NOT OFTEN that two biographies of the same individual are published in less than a year, and it is even more unusual when the same company publishes both of them. Such is the case, however, with Annie Goodrich, a dynamic personality whose contributions to nursing inspired the talents of her two biographers.

Miss Goodrich is a combination of the visionary and the realist, and nurses of today are deeply indebted to her for their professional status. In her fight for higher standards for nursing education she was unyielding, and often, especially during World War I, she faced strong opposition from the advocates of nurse aides, among whom was Dr. S. S. Goldwater.

Miss Goodrich was responsible for the establishment of the Army School of Nursing and served as its first dean until 1919, when she returned to her former position as director of nurses at the Henry Street Nursing Service in New York and assistant professor of nursing and health in Teachers' College, Columbia University.

When the Goldmark report ("Nursing and Nursing Education in the United States") was published in 1918 and strongly recommended endowments for university schools of nursing, the Rockefeller Foundation responded with a grant of $150,000 for an experiment in nursing education on the university level. Yale was chosen as the site for this experiment and Annie Goodrich the dean. As Mrs. Koch says, this was the "crowning achievement" of a brilliant career and Dean Goodrich served her profession in this capacity until her retirement in 1934.

Both books are illustrated, indexed and documented. "Militant Angel" also includes an appendix outlining Miss Goodrich's degrees, awards, memberships, and positions, and a chronological list of her writings. Hospital administrators and nurses should consider these books required reading to obtain the background of the nursing education problem—H.T.Y.

Patient's-eye view

A PAIN DISCOVERS ME. Henry H. Harper. Cedar Rapids, Iowa, the Torch Press. 1950. 88 pp. $1.35.

The merit of this little account of the author's sojourn in the Mayo Clinic and his consequent hospitalization at St. Mary's Hospital in Rochester, Minn., lies in its message to the medical staff and hospital personnel: Remember your patient is a person.

The diagnostic machinery of a modern clinic and the administration of a hospital undergo the scrutiny of a person suffering a serious kidney ailment, and, though Mr. Harper recounts his experiences rather humorously and surely without rancor, a great deal about "patient relations" can be read between the lines. His callous intern and his ex-cab-driving barber are characters who could be duplicated in many hospitals, and, sadly enough, memories of their vicious and unfeeling treatment outlive those of good nursing care.

The American Hospital Association's 16mm. film, "As Others See Us," which can be rented from the library at $4 for two weeks, teaches the same lesson in public relations as this book. Both the book and the film are recommended for alerting hospital personnel to their duty to the patient as a person.—H.T.Y.

Manual for board members

THE BOARD MEMBERS' MANUAL—HOW TO PRODUCE AND USE IT IN BOARD EDUCATION. Charlotte K. Demorest. National Publicity Council for Health and Welfare Services, Inc., 257 Fourth Avenue, New York 10, N. Y. 1951. $1.

In a constant effort to improve the working relationships between the board members and himself, the administrator is searching for helpful ideas and materials. Some hospitals are already using a type of manual or handbook which is kept up to date and is the property of the board member while he is in office. To other administrators this may be a new approach. In any event, this new publication will present some concrete information on how to prepare a usable manual and suggestions on getting the most good out of the manual once the procedure has been started.

The two main sections discuss "what you put into a board member's manual" and "the format of a manual" *e.g.*, design for flexibility, importance of variety for readability, arranging the material, etc. Using manuals as a part of board member education makes it much easier to orient the new board member to his responsibilities.

Inquiries about books reviewed in the Literature department should be addressed to the American Hospital Association Library—Asa S. Bacon Memorial, 18 E. Division Street, Chicago 10. The department is edited by Helen V. Pruitt, librarian.

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A system for avoiding errors in medical gas administration

LEONARD P. GOUDY

THERE HAVE BEEN times in the recent past when a patient has died in a hospital because of tragic substitution of the *wrong* medical gas at a crucial moment. At least two such cases were reported in this country in the past year, and only last month a British medical journal reported that a baby died from the administration of carbon dioxide gas instead of oxygen. The hospital took the responsibility, but the loss, of course, could never be redeemed.

A quiet movement has been under way for some time to make such blunders all but impossible. Now, a solution is close at hand—one that will be relatively inexpensive and thus far appears satisfactory to all concerned.

The Compressed Gas Association, the American Hospital Association, and the American Society of Anesthesiologists, working together, provided the solution and formulated the changes that will be necessary in medical gas equipment. The changes will apply only to connections on anesthesia machines and respirators and will not apply to equipment used in oxygen service throughout the hospital. A successful trial run was conducted at New York City's Lenox Hill Hospital in May with the cooperation of Superintendent John H. Hayes, a past president of the American Hospital Association.

The three associations now have adopted the modification as their standard and have sent it on to the American Standards Association. Even now, medical gas suppliers are going ahead with their part of the program, which involves modification of the valves on the cylinders.

Mr. Goudy is secretary of the Council on Administrative Practice and purchasing specialist for the American Hospital Association.

EVOLUTION OF PLAN

Since the problem was mainly mechanical—a question of redesign of parts—the manufacturers of medical gas equipment played a very important role. Interchangeability of parts, usually a boon to manufacturing and purchasing, had become a hazard, and something had to be done to make certain parts non-interchangeable. A step backward, in effect, was necessary. This step had to be taken gingerly, however, to avoid throwing the entire industry into confusion. Standardization of gas cylinder valves and anesthetic machine yokes had been accomplished long before, but there were certain minor variations from one company to another which required careful study and hours of discussion before a universally acceptable plan for modification could be worked out.

At length, through the diligent efforts of the Valve Thread Standards Committee of the Compressed Gas Association and others, a method was devised which would, with a minimum of effort and cost, make it almost impossible to connect inadvertently any but the correct cylinder of gas to its corresponding yoke on the anesthetic machine. A system of matching pins and holes was the answer to the puzzle—the pins on the yoke and the holes in the cylinder valve—each gas with its own code and its own yoke on the anesthetic machine.

Under this system an operator attempting to attach a carbon dioxide cylinder to an oxygen yoke, for example, would be aware of the error instantly. The coupling just wouldn't fit correctly. In the words of the report of the Valve Thread Standards Committee, "A system cannot be devised that will not permit of willful violation by a person who is willing to assume the risk of such action. However, it is the aim of this committee to provide a system that will . . . warn the conscientious anesthesiologist of a mental lapse that might lead to putting a cylinder of gas in a wrong position on the anesthetic machine."

At the June 7, 1951, meeting of the Valve Thread Standards Committee, which John Hayes and I attended as representatives of the American Hospital Association, initial agreement was reached upon the "proposed system of non-interchangeability of yoke type connections on medical gas cylinders." Subsequently, the proposal was adopted by the executive board of the Compressed Gas Association as a CGA standard, by the American Hospital Association conditionally, and by the American Society of Anesthesiologists. The proposal was also sent to the National Fire Protection Association and other organizations directly concerned. The committee wished to have these organizations' approval of a proposal that the non-interchangeability system be submitted to the American Standards Association for adoption as an American standard.

Approval by the Board of Trustees of the American Hospital Association was given only after careful prior consideration by the Committee on Purchasing, Simplification and Standardization, headed by Neal R. Johnson, purchasing agent of the Johns Hopkins Hospital, Baltimore. Similar action has been taken by the other organizations to which the proposal was referred.

INTERNATIONAL PROPOSAL

When action has been taken by the American Standards Association, it is proposed by the Compressed Gas Association that the non-interchangeability system be

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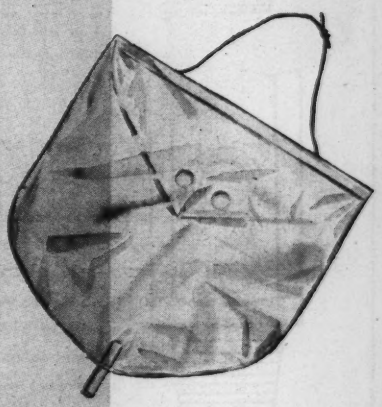

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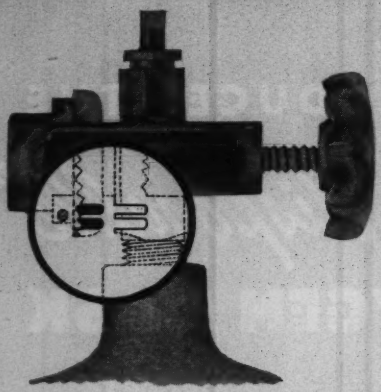
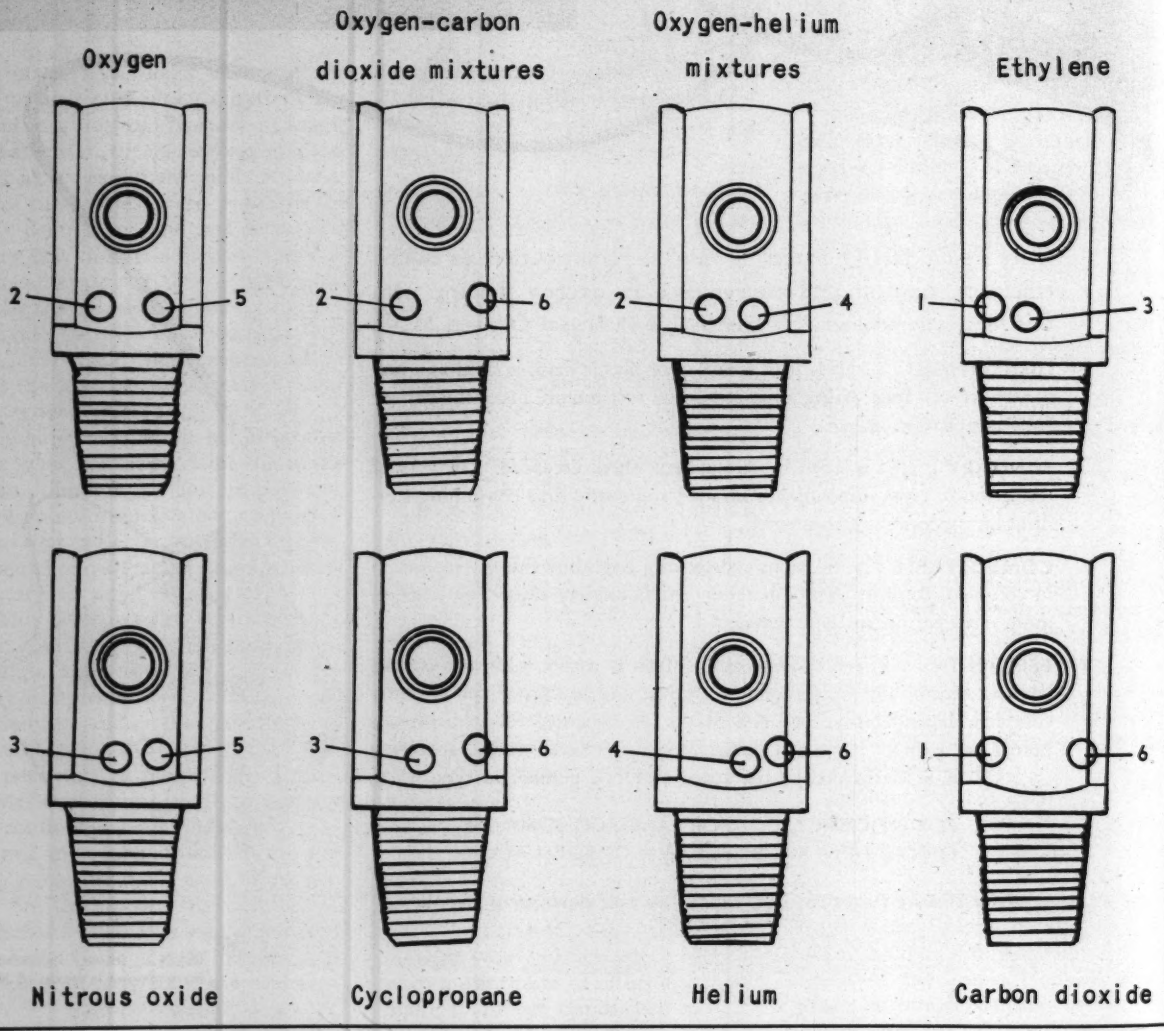


A different combination for each gas

The new system for preventing erroneous interchange of medical gas cylinders is built around the matching of pins and holes. The pins are installed in the cylinder yoke on the hospital's anesthetic machine. The holes are drilled in the body of the valve that comes with the cylinder. For any one gas there is only one combination of pins and holes. Unless the right cylinder is connected, the holes and pins will not match and the two parts will not fit together.

Illustrated at the left is an anesthetic machine yoke with the medical gas cylinder valve inside it. The cutaway circle shows how the pins fit into the holes (slightly exaggerated for visual presentation). Below are the eight assigned combinations of holes in cylinder valve bodies. Numbers indicate the standard designation for each hole.



submitted to the International Standards Organization for adoption by that group.

Meanwhile, with this guarantee of support, suppliers of medical gases are proceeding with their part in the program (drilling of holes in cylinder valves) which, engineering-wise, must precede the installment of pins on yokes of anesthetic machines.

The eight gases and gas mixtures now provided for in the system are: (1) Oxygen, (2) oxygen-carbon dioxide mixtures (seven per cent or less of carbon dioxide), (3) oxygen-helium mixtures (80 per cent or less of helium), (4) ethylene, (5) nitrous oxide, (6) cyclopropane, (7) helium, and (8) carbon dioxide. The present system provides for 10 different gases or gas mixtures, so two combinations

(Continued on page 88)

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Medical gas safeguards—a small price for the patient's welfare

CHARLES U. LETOURNEAU, M.D.

THE PROPOSED SYSTEM of matching pins and holes for flush-valve gas cylinders and anesthetic machines recommended by the Compressed Gas Association, the American Hospital Association and the American Society of Anesthesiologists is a long-overdue measure for the prevention of anesthetic deaths caused by the administration of the wrong gas to the patient.

The new system should be an excellent check upon the inattentive and a foil for the inadvertent. Of course, a careless oaf can defeat the best planned safety program and circumvent the safeguards that are devised for the protection of the patient. The careless ones will always be with us, and it is not claimed that this system will achieve 100 per cent prevention of accidents from anesthetic gases.

The system applies only to anesthetic machines that use flush-valve cylinders. It does not apply to the screw valve type of cylinders that are in frequent use elsewhere in the hospital.

Nevertheless a new weapon has been placed in the hands of the hospital administration to enable it to carry out its duty of protection for the patient. According to law a hospital is responsible for using "due and reasonable care" in employing all available methods for the protection of its patients. The standards of care demanded of a hospital are not the highest that are in existence but only those that can be reasonably provided within the community and under the circumstances in which the hospital functions. The standards of care are also limited by the courts to the prevention of accidents that are foreseeable or that might occur in a particular procedure, technique or operation.

A good standard of care is not a valid defense to an action for negligence if a better standard of care is available in the community and is in use by other hospitals in that same community. Only the best standard of care that is available in that community will be accepted by the courts as a defense.

The increasing frequency with which accidents have been reported due to application of the wrong anesthetic gas to the patients should certainly make all hospitals aware of the great need for some device to prevent this type of accident. Such accidents can now be classified as foreseeable and, to a certain extent, preventable. The system of matching pins and holes is now available in every community. The cost of equipping anesthetic machines is said to be negligible. From the legal point of view it would seem that the provision of these safeguards would fall under the heading of "due and reasonable care."

Under the circumstances, the failure of a hospital to convert its anesthetic machines to the system of matching pins would seem to be a failure to provide the patient with the reasonable protection to which he is entitled on admission to the hospital. In a court of law this might give rise to a presumption of negligence, and the attorney engaged by the hospital to defend an action based upon the mistaken administration of a lethal gas would have a most unenviable task.

The conversion to the recommended system would seem to be a small price to pay for the increased safety of patients who are obliged to undergo an anesthetic.

Dr. Letourneau is secretary of the American Hospital Association's Council on Professional Practice.

(Continued from page 86)

are open for future assignment.

In the mating of the two pins on the anesthetic machine yoke with the two corresponding holes in the cylinder valve body, the committee has assigned each gas and gas mixture a different position for pins and holes. For each of the eight types listed above, then, medical gas suppliers are currently drilling holes in the valve bodies in two of six standard positions, depending upon the type of gas to go into the cylinder. These holes do not affect the operation of the valves even though pins to fit into them are not yet on the machines.

For ease of reference, the committee has numbered the possible positions from one to six (see illustration). They lie on an arc at a radius of 9/16-inch from the valve outlet hole, are 3/16-inch in diameter, and 7/32-inch deep. A line drawn 30 degrees to the left of the centerline of the valve outlet would pass through the No. 1 position. Positions 2 to 6 are at intervals of 12 degrees. Since the positions overlap, it is impossible to use two holes adjacent to one another. This means that the maximum number of combinations is 10, eight of which have already been assigned. If more additional combinations than the two now vacant are desired, the committee states that this can be accomplished by providing sufficient stock in the valve body to drill another row of holes.

Since holes will be drilled in the valves of existing cylinders when they are returned to the gas supplier for refilling, it is expected that all existing medical gas cylinders in this country will be modified within a few months.

The Valve Thread Standards Committee has recognized that there is still danger of incorrect filling of cylinders by gas suppliers unless they use a similar system on their cylinder filling connections, and it has recommended to the latter that this be done.

FIELD STUDY OF SYSTEM

In the field study conducted at Lenox Hill Hospital in New York City, seven anesthetic machines were involved (all made by the

same manufacturer) and it was reported that no difficulty was encountered in using the converted equipment. It was said that pins and holes actually appeared to facilitate attachment of cylinders to yokes by tending to line up properly the nipple and outlet. Dr. Ralph M. Tovell, a member of the American Society of Anesthesiologists who was present at the committee meetings, reported favorable comments from a number of anesthesiologists with whom he had discussed the non-interchangeability system.

Although the bulk of the labor involved in these modifications falls to the compressed gas industry, hospitals have a definite responsibility in bringing the program to fulfillment.

THE HOSPITAL'S ROLE

As owners of anesthetic machines, the decision for final conversion (installation of pins on yokes) rests with them. The Compressed Gas Association has recommended that actual changes on the machines be made by the manufacturers, but requests for these changes must come from the hospitals. It is true that without conversion the machines will continue to function exactly as before, but the expense and effort that would be required of hospitals to do their part is exceedingly minor in comparison to what has already been done. If it is not done, the chance for error still will exist, with the hospital in a critically vulnerable position from a legal standpoint.

In amost all instances, conversion of anesthetic machines will be a matter of only a few dollars expense on the part of the hospital, with a minimum of out-of-service time for the equipment. With the type of equipment used at Lenox Hill Hospital, all that was required was a simple bracket for each of the anesthetic machine yokes.

PURCHASING COMMENT

Floor wax and polish

THE MILLS of the gods grind slowly, but they grind exceeding fine.

Much of the confusion in the field of hospital purchasing has resulted from extravagant claims by some manufacturers and distributors of products intended for sale to hospital executive housekeepers.

Ever since the middle of 1949, pressure has been brought to bear on the Federal Trade Commission to bring about some order in this field. Finally, on May 11, 1951, a meeting was called by the Federal Trade Commission for the purpose of compiling trade practice rules for the floor wax and floor polish industry.

At this time, it is a little early to predict results forthcoming from this meeting, but if nothing else resulted than the enforcement of rules which have been on the books for a considerable time, hospital purchasing agents will be in a much better position. For instance, there are rules on the books now which are intended to regulate the use of such terms as *wax, slip-proof, slip-resistant, waterproof, water-resistant, spot-proof,* and *heavy duty.* But such rules have not been enforced, and purchasing personnel have not been afforded the protection to which they are entitled.

It has long been known that purchasing agents who are cognizant of the dangers inherent in the use of a wax which is not slip-proof have endeavored to protect the hospital by means of the insurance of suppliers whose product did not meet the requirements. If, as a result of these meetings, we have a standard with which we can demand compliance, a forward step will have been taken and the use of terms which are false, misleading or deceptive will have to be discontinued.

One of the proposed rules deals with the misuse of the term *wax* and says it is an unfair trade practice to use the term *wax* as descriptive of "any industry product which deposits on a floor surface to which it is applied, and after evaporation of the solvent or carrier, a film which contains less than 50 per cent wax, by weight, and which is not a plastic solid at room temperature, does not adhere to the surface to which it is applied, does not cohere sufficiently for cold molding, is not capable of having its gloss increased by buffing, and is not hydrophobic."

Further, in regard to the slip-proof waxes, it is proposed that the rules say, "In the sale, offering for sale, or distribution of any industry product, it is an unfair trade practice to use the terms *slip-proof, nonslip, nonskid,* or terms of like import, as descriptive of such product unless it will completely prevent slipping on any floor surface to which it is applied for the duration of the product thereon."

This subject is emphasized here because there has been much discussion regarding the fact that many products offered do not serve the purpose for which they are purchased. Whether this is the result of improper use or extravagant claims is difficult to determine, but it is apparent that ground rules are essential and should be very welcome.

Medical gas cylinders

The article on page 84 of this issue describes a new system developed to prevent interchanging of medical gas cylinders on anesthetic equipment and is important reading for all purchasing agents and administrators.

The purchase of equipment is a concern of the purchasing department, and improvement of such equipment now becomes one of the purchasing agent's responsibilities.

The adapters recommended for use of anesthetic equipment are not a device arising out of desire for further sales by manufacturers but a life-saving measure which

can be easily applied at small cost. They will, in the opinion of many qualified persons, eliminate serious mistakes.

Wall washing

According to a survey recently conducted by the Hospital Bureau of Standards and Supplies, about 24 per cent of hospitals are now using wall-washing machines. A comparatively small percentage of the hospitals surveyed have outside companies wash their walls on contract.

The fact that about one-fourth of the hospitals surveyed are now using such labor-saving equipment would seem to indicate that this is a matter to be investigated by those hospitals which are not doing so. Many of the hospitals not using such equipment said that some of their walls were rough and wall-washing machines would not operate efficiently under such conditions. It is claimed, however, that some of the equipment now available will satisfactorily wash rough surfaces, and it would seem to behoove hospitals to investigate such statements. Purchasing personnel might well justify their position by instituting such an investigation if wall-washing equipment is not already in use in their institutions.

Penicillin regulation

Purchasing agents probably have noticed that all labels on aqueous suspensions of penicillin now bear a statement advising that the drug requires refrigeration at 59° F. (or 15° C.). This is required by a Food and Drug Administration regulation which became effective on May 26. From that date, all material which was processed for sale by a manufacturer had to be so labeled.

This step was felt necessary by the Food and Drug Administration since it was apparent to them that there was a loss of potency and clumping, together with some change in color in the aqueous suspensions of penicillin when subjected to elevated temperatures over a long period.—L. P. G.

The Purchasing department is edited by Leonard P. Goudy, purchasing specialist.

Current price trends

AT THE BEGINNING of July, it was apparent that a slight business decline had developed in the preceding 30 days. After four weeks of small but steady decreases, the overall index for wholesale commodity prices rested at 181.1 per cent of the Bureau of Labor Statistics' 1926 "normal." This was 0.8 per cent lower than the preceding month's comparable index.

Business leaders attributed the decline to the shift from production of consumer goods to defense materials. Defense orders apparently have not filled the gap left by loss of civilian output. The outlook, however, does not indicate large or long-continuing price decreases.

Already, the reserves of steel for defense orders are running so high that steel men are convinced that Controlled Materials Plan allotments for this product are unavoidable. Since 85 per cent of the steel supply will be slated for defense within two months, steel executives believe that a fair distribution of the remaining 15 per cent is impossible and predict that it will be necessary to put all civilian consumers of steel under the Controlled Materials Plan.

TABLE 1—GRADUAL DOWNWARD DRIFT

Weekly Index Numbers of Wholesale Prices—1926=100

COMMODITY	June 20 1950	June 27 1950	May 29 1951	June 5 1951	June 12 1951	June 19 1951	June 26 1951	% of Change 6-27-50 to 6-26-51	% of Change 1-2-51 to 6-26-51
All commodities	157.4	157.4	182.5	181.9	181.7	181.6	181.1	+15.1	+2.4
Farm products	166.6	165.4	199.8	197.5	198.0	199.1	197.5	+19.4	+4.3
All foods	162.1	162.4	188.4	187.3	186.9	187.3	186.5	+14.8	+2.5
Textile products	136.9	137.3	182.9	182.9	182.4	182.1	181.2	+32.0	+5.1
Fuel and lighting materials	132.9	132.8	138.5	138.5	138.7	138.7	138.7	+ 4.4	+1.9
Metals and metal products	171.9	171.9	189.4	189.3	189.0	188.2	188.2	+ 9.5	+4.3
Building materials	202.8	203.7	227.3	227.2	226.8	226.6	225.3	+10.6	+1.3

This weekly wholesale price index is designed as a weekly counterpart of the monthly wholesale price index. It is based on a sample of about one-eighth of the commodities in the comprehensive sample and therefore should be regarded as an indicator of price trends rather than as a final compilation. The monthly index should be used for fuller coverage.

Source: Bureau of Labor Statistics.

TABLE 2—SLIGHT DOLLAR INCREASE

Monthly Index Numbers of Wholesale Prices—1926=100

COMMODITY	May 1941	May 1943	May 1945	May 1947	May 1949	May 1950	April 1951	May 1951
All commodities	84.9	104.1	106.0	147.3	155.7	155.9	183.5	182.8
Farm products	76.4	125.7	129.9	175.4	171.5	164.7	202.5	199.6
Foods	79.5	110.5	107.0	159.6	163.8	159.9	185.7	187.2
Textile products	83.0	97.4	108.8	139.9	140.4	136.1	182.8	181.9
Cotton goods	91.0	112.6	138.6	195.4	172.1	172.0	236.2	234.1
Fuel and lighting materials	75.6	80.8	83.7	103.4	130.1	132.9	138.1	137.5
Anthracite coal	80.7	89.7	95.6	112.1	133.7	139.2	152.8	151.0
Bituminous coal	102.9	116.1	123.2	145.5	188.9	192.6	195.4	195.0
Electricity	67.7	59.5	58.5	64.1	68.2	66.6	*	*
Gas	80.1	77.5	76.4	85.0	90.9	87.2	93.3	*
Building materials	100.4	110.5	117.3	176.2	193.9	198.1	228.5	227.8
Brick and tile	91.9	98.9	110.7	134.5	160.8	163.9	180.8	180.8
Cement	91.5	93.9	99.4	114.0	134.3	134.9	147.2	147.2
Lumber	116.8	138.1	154.9	270.3	285.2	310.8	361.0	359.0
Paint and paint materials	89.3	102.2	106.4	164.3	157.7	136.8	164.7	163.7
Plumbing and heating materials	83.0	90.4	92.4	119.1	154.8	156.4	183.7	183.7
Structural steel	107.3	107.3	107.3	127.7	178.8	191.6	204.3	204.3
Other building materials	96.3	101.6	104.1	144.8	170.5	172.7	198.3	198.2
Drugs and pharmaceutical materials	98.7	106.1	106.8	173.6	123.6	122.3	184.5	185.2
Raw materials	79.7	114.0	117.7	158.4	165.9	166.3	197.7	195.5
Semi-manufactured articles	86.4	93.0	95.0	146.0	149.4	145.8	187.1	186.5
Manufactured products	87.1	100.7	101.8	142.0	151.5	152.1	175.9	176.0
Purchasing power of the dollar	$1.177	$.960	$.943	$.678	$.642	$.641	$.545	$.547

**Figures not available at press time.*
Source: Bureau of Labor Statistics.

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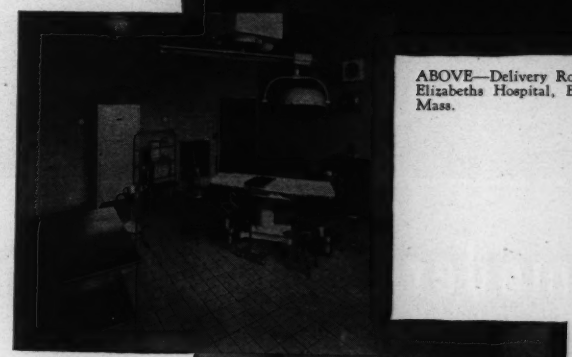
ABOVE—Delivery Room, St. Elizabeths Hospital, Brighton, Mass.



ABOVE—Operating Room, Cambridge City Hospital, Cambridge, Mass.

BELOW — Nursery at St. Josephs Hospital, Yonkers, N. Y.

ABOVE—Stretcher Alcove St. Vincents Hospital, New York, N. Y.

Our engineers will be happy to assist and advise you on any hospital equipment problem. Send for new catalog which has DETAILED specifications for every item. Many NEW items listed.

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Hospital employee, Mrs. Stott, in Main Kitchen. Modern Gas Equipment includes:

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- 2 Garland Roasting Ovens
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modern GAS kitchens

feature cooking speed and flexibility at Mercy Hospital

Sister Mary Leah, Dietitian, and Sister Mary Anselm receive 1950 Honor Award plaque from Mr. O. T. Carson. Plaque reads: "For Highest Standards of Sanitation and for superlative Achievement in Storing, Handling, Preparing and Serving Food."

Sister Mary Leah R.S.M., Dietitian of Springfield's Mercy Hospital says:

"I know that the *speed* and *flexibility* of our Modern Gas Equipment make it possible for our busy food department to keep on schedule regardless of type of diets required."

In addition to the main kitchen, Mercy Hospital is equipped with a Special Diets Gas Kitchen, 2 Cafeterias featuring Modern Gas Equipment, and a Coffee Shop utilizing Gas for food preparation. Gas cooking is clean . . . fast . . . economical . . . and versatile, to meet the fluctuating demands of hospital service.

For optimum efficiency and economy in Volume food preparation, check the values of Modern Blue Flame Gas Cooking with your Gas Company Representative. Call him today.

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Master Menu revisions make this service even more effective

FOR THE PAST two and one-half years, dietitians and other directors of hospital food service have had the benefit of a simple, efficient and reliable menu planning aid. This is the American Hospital Association's Master Menu, which was introduced in HOSPITALS in February 1949 and has since been a monthly feature of this magazine.

Now the Master Menu has been revised and completely new Master Menu kits are being distributed, including a valuable new booklet —the "Master Menu Diet Manual."

When the Master Menu first appeared it was announced as a food-planning service for the normal and seven most frequently used special diets, with the aim of giving patients more appetizing and attractive meals as well as nutritional adequacy.

Economy in the use of food and preparation time was an important feature, and nutritional adequacy was assured in all the diets, except, of course, the *full liquid diet.*

None of these original purposes of the Master Menu have been altered. The revision was motivated by a continuing desire for improvement and was based upon extensive study, new thinking in the field, and the suggestions of dietary authorities and users of the Master Menu service.

Dietitians have pointed out that the old wall cards did not include space to specify the quantity of each food to prepare. Many directors of food service also wanted to write instructions to the cook or kitchen staff relative to the preparation or serving of foods on the Master Menu.

To fill these needs, two new columns headed "Census or Quantity" and "Instructions" have been added to each of the three wall cards. The added columns also appear on the three new transfer slips for breakfast, dinner, and luncheon or supper.

Another need was for a listing of portion sizes. Users of the Master Menu know that seven of the diets are nutritionally adequate, but that adequacy is premised on a specific size of serving of each food. Portion sizes now are printed on wall cards in small boxes at the top corners.

NEW DIET MANUAL

The "Master Menu Diet Manual," included in all kits, is a valuable guide to directors of food service who are using the Master Menu. This manual includes basic information on each of the eight Master Menu diets, such as the basic food pattern for the diet, which items on the Master Menu are served on each diet, and lists of the foods allowed and foods to avoid for many of the diets. Supplementing this discussion of Master Menu diets are similar analyses of 15 other special diets which are modifications of those in the menu. Among these is a diet for the older person and diets for children.

Part of the Master Menu revision has been the renaming of certain diets. All diets on the menu are the same as the original ones, but some have been given new names in accordance with the trend toward standardization of dietary terminology.

Diets on the Master Menu are the *normal, soft, full liquid, high protein* (approximately 120 grams protein for entire day), *high calorie* (approximately 3,000 calories for entire day), *low calorie* (approximately 1,200 calories for entire day), *low fat* (40-50 grams fat for entire day), and *measured or weighed.*

THREE STEPS

HOSPITALS readers will find no change in the Master Menu as printed in each issue of the magazine. Nor will the procedure for using the menu be changed. As before, there are three steps for getting the Master Menu from the magazine page to the hospital kitchen. Step 1 is HOSPITALS; step 2, the transfer slips, and step 3, the wall cards.

Step 1: Each issue of HOSPITALS has a complete month's Master Menu, listed by day for the succeeding month. The Master Menu for each day consists of 36 items divided by short rules into three groups. The first group, numbered 1 through 6, is the breakfast menu. Dinner foods are numbered 7 through 21, and luncheon or supper foods are numbered 22 through 36.

This numbering system is the key to using the Master Menu. Transfer slips and wall cards are numbered to correspond to the original listing in HOSPITALS, thus the transfer slip and wall card for breakfast are numbered for items 1 through 6. For the dinner, both transfer slip and wall card are numbered for items 7 through 21, and the slips and cards for luncheon or supper are numbered 22 through 36.

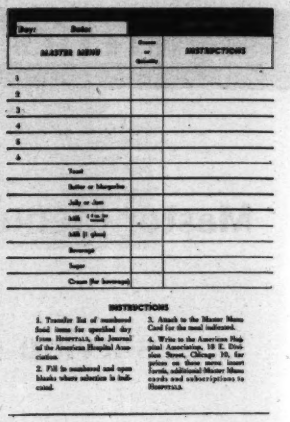
Foods to be served on the normal diet are set in **boldface type** in HOSPITALS' listing of the Master Menu. A glance through the Master Menu in this issue of HOSPITALS will show that items numbered 1, 3, 4 and 6 are on the *normal diet* (set in boldface type) for each day's breakfast menu. Similarly, food items on the dinner and

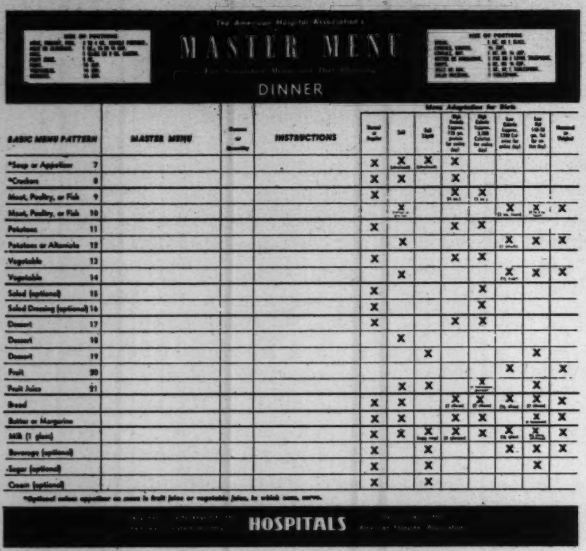
The Dietetics Administration department is edited by Margaret Gillam, dietetics specialist.

MASTER MENU

BREAKFAST

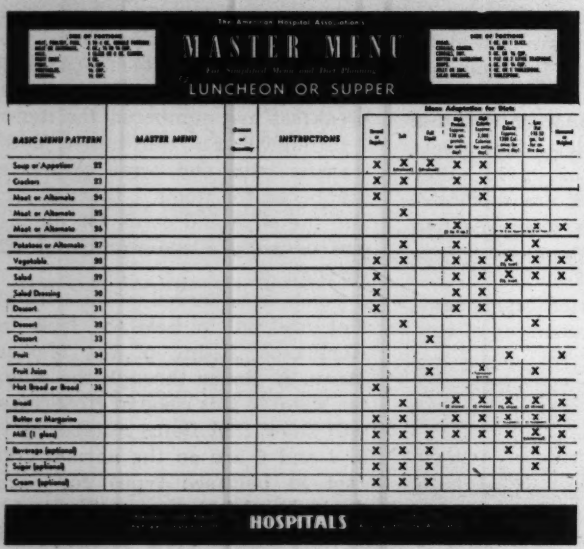
THE BREAKFAST wall card (at left) is for Master Menu foods numbered 1-6. *At right* is the transfer slip on which the breakfast menu should be written.


MASTER MENU


MASTER MENU

DINNER

DINNER wall cards are numbered 7-21. When the transfer slip is attached to the wall card, it will cover the second, third and fourth columns.


MASTER MENU

LUNCHEON OR SUPPER

LUNCHEON or supper wall cards are for selections numbered 22-36. Menus for the eight diets are charted in the columns at the right on the card.

luncheon or supper menus with the same numbers are consistently set in boldface type. This numerical pattern is the same in every daily Master Menu.

NUMBERS ARE GUIDE

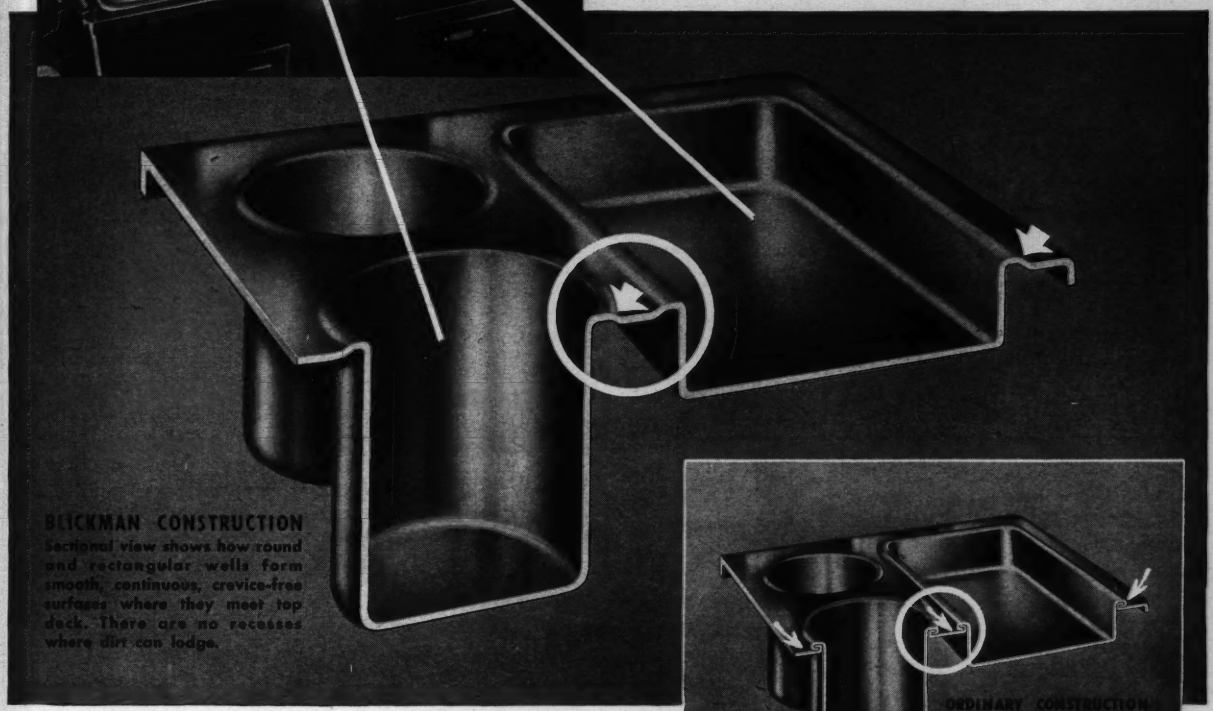
Just as foods to be served on the *normal diet* consistently carry the same numbers in the daily Master Menus, foods to be served on each of the seven special diets in the menu are consistently numbered. Special diet foods appear in lightface type in HOSPITALS listings. Numerical patterns for the special diets cannot be detected until the Master Menu has been transferred from the magazine page to transfer slips and attached to the wall cards.

Step 2: Printed transfer slips have been prepared for each of the three daily meals. Hospitals may purchase pads of transfer slips from the American Hospital Association or they may mimeograph their own. Each slip has three columns, headed "Master Menu," "Census or Quantity," and "Instructions." There are horizontal rules extending across the slip which are planned for double-spaced typewriter lines to facilitate typing the menu.

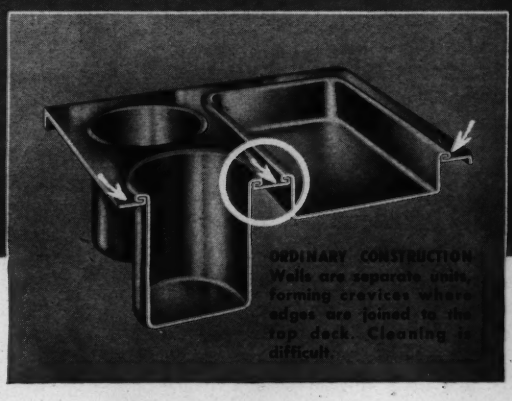
At the top half of the breakfast transfer slip, the lines are numbered 1 through 6, corresponding to the daily breakfast menu in the Master Menu. On these lines the numbered items for each day's breakfast are typed or written in.

At the bottom of the breakfast transfer slip, the lines are not numbered but list foods customarily served at each breakfast, such as toast, butter or margarine, and

Food Conveyor with SEAMLESS TOP assures greater sanitation!



BLICKMAN CONSTRUCTION
Sectional view shows how round and rectangular wells form smooth, continuous, crevice-free surfaces where they meet top deck. There are no recesses where dirt can lodge.



ORDINARY CONSTRUCTION
Wells are separate units, forming crevices where edges are joined to the top deck. Cleaning is difficult.

This new development in food conveyor design means faster cleaning and better sanitation. The round and rectangular wells are *actually part of the top deck.* There are no joints, openings, or crevices in which dirt or food particles can lodge. The highly-polished stainless steel surfaces, where wells meet top deck, are smooth and continuous, easy to keep clean and sterile. Blickman-Built electrically-heated food conveyors are the only standard models offering a crevice-free top and one-piece body. This seamless construction protects insulation and electric heating elements—permits cleaning by live steam and hot water. When you purchase your next food conveyor, check these and other outstanding features for sanitation, durability, and efficient performance. There are no finer conveyors made.

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the *New* Selective Menu Food Conveyor

• An important contribution to successful diet-therapy. *One* conveyor affords wide variety of inset arrangements for selective menus. Built with sanitary seamless top and one-piece crevice-free body. Ask us about Model ALS-4922.

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beverage. These unnumbered items on the breakfast transfer slip—and they are also unnumbered on the breakfast wall card—are foods that should be served at the meal but are not included in HOSPITALS listings of the Master Menu. Unnumbered items appear on the transfer slips and wall cards for dinner and luncheon or supper as well as breakfast.

Transfer slips for dinner are numbered 7 through 21, for luncheon or supper 22 through 36, corresponding to HOSPITALS listing. For each of the three meals, the dietitian or other director of food service, should type or write on the appropriate transfer slip the foods listed in HOSPITALS, being careful to match the numbers in the original Master Menu listing with the numbers on the transfer slips.

Step 3: Wall cards for breakfast, dinner, and luncheon or supper are approximately 12 inches long by 11½ inches deep, of durable cardboard with a laminated surface.

The first column at the left on each wall card is headed "Basic Menu Pattern" and lists the type of food served at the meal. Numbers follow the food types that are on the Master Menu. Unnumbered foods are in the column as well, below the numbered items. The second, third and fourth columns on the wall cards are the same size as the transfer slips and have the same headings. Transfer slips are attached each day to the wall cards with gummed transparent tape. Because the cards are laminated, the tape is easy to remove at the end of the day.

PATTERN FOR SPECIAL DIETS

In the remaining eight columns at the right-hand side of the wall card are charted the eight Master Menu diets. Large X's specify which foods are served on each diet.

Wall cards should be placed in the same spot in the kitchen each day so that they can be consulted for the menu, instructions, and the quantity to prepare.

The procedure for using the Master Menu outlined above is basically the same as it has always been. Wall cards are now larger and contain more information. Transfer slips are correspondingly larger.

For those who are using the service, frequent reference should be made to the "Master Menu Diet Manual." The Master Menu is a flexible service that may be adapted to the particular needs of the individual hospital and used in many different ways. The manual explains a simple method for making a selective food service with the Master Menu. Fifteen modifications of Master Menu diets are discussed. Recommendations are given on how to select substitute foods when the Master Menu foods cannot, for one reason or another, be served. Finally, there are hints on how to use the Master Menu for better meals and meal-planning in the hospital.

DIETETICS ADMINISTRATION COMMENT

Fewer human errors

A TRAGIC EPISODE in a Chicago hospital recently has brought about a new idea. It is another example of the cooperation of hospitals and industry always searching for ways to eliminate the possibilities of human error.

The tragedy was the death of several infants. The cause — a formula room employee apparently substituted a cleaning compound for a powdered formula ingredient when preparing formulas for infant feedings.

It is now reported that a manufacturer of cleaning compounds has, at the instigation of the Chicago Health Department, modified its institutional detergent used particularly for the cleaning of equipment for preparing and containers for dispensing baby formulas, to contain a harmless food coloring material (8D-1)*. This distinctive coloring should prevent its mistaken use as an ingredient of hospital food preparations or baby formulas.

Even this added safeguard should not preclude the establishment and enforcement of strict regulations covering the storage, handling and dispensing of detergents and cleaning compounds in the formula preparation room.

The Association's manual, "Procedures and Layout for the Infant Formula Room," places the responsibility in this manner: "It is the duty of the formula room supervisor to set up 'written procedures for the various operations including directions for cleaning, and of supervising all procedures and directions to assure that they are understood and carried out.'"

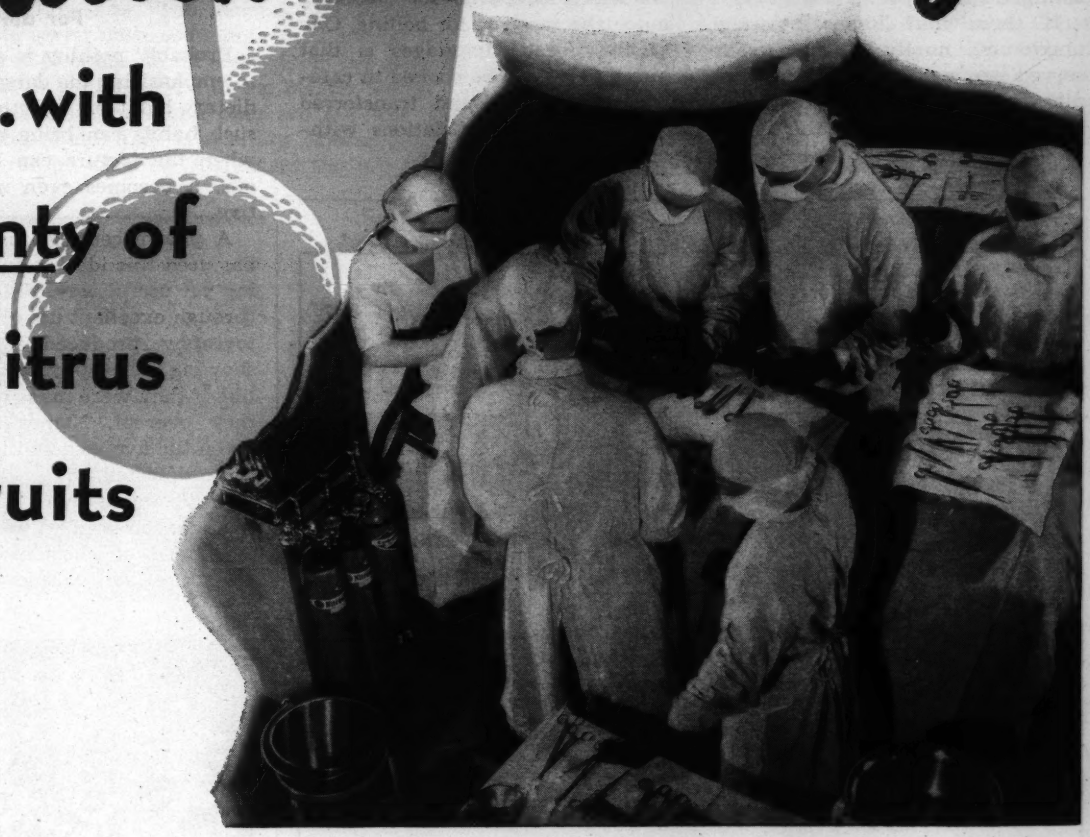
Water-heating equipment

"Enough Hot Water — Hot Enough" is a recent publication on how to select water-heating equipment for commercial and industrial kitchens. (8D-2).* It discusses the need for ample quantities of both 180-degree and 140-degree water to meet modern standards of sanitation. The various types of dishwashing equipment are described, as are the different varieties, arrangements, and sizes of water-heating apparatus. Two methods are given for selecting the proper combination of storage tank and gas water heater to avoid either undersizing or oversizing. Basic information is furnished on water and gas piping, venting and required clearances.

An ample supply of 140-degree water is required for dishwashing, pot washing, general cleaning and other uses. The increased demand for sanitation by health officers and the public now requires more and hotter water in institution kitchens. Dishwashing requires adequate 170-degree to 180-degree water supply for the final rinse

*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

hasten the recovery ...with plenty of citrus fruits



For all patients on surgical wards, to help insure maximal tissue repair and wound healing,[1,2,3] sound supporting therapy today usually calls for the routine administration of adequate vitamin C,[4] both pre- and post-operatively. The nutritional preparation of the patient is "best carried out by the normal oral route whenever possible."[5] Fortunately, most everyone likes the pleasing flavor of Florida citrus fruits, so rich in vitamin C, and contributing other nutrients.* Whether fresh, canned or frozen, it is possible—under modern techniques of processing and storage—for citrus fruits and juices to retain their ascorbic acid content, and their flavor appeal, in very high degree over long periods.[6,7] Their energizing influence, because of their easily assimilable fruit sugars,[8] also gives constructive assistance in hospital care.

FLORIDA CITRUS COMMISSION · LAKELAND, FLORIDA

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FLORIDA

Oranges • Grapefruit • Tangerines

*Citrus fruits—among the richest known sources of vitamin C—also contain vitamins A and B, readily assimilable natural fruit sugars, and other factors, such as iron, calcium, citrates and citric acid.

to insure thoroughly sanitary dishes. The use of this 180-degree rinse assures that the dishes and silverware are germ-free and brings about savings through the elimination of toweling and polishing.

If these four items—(1) the maximum number of persons served per meal, (2) whether the dishwashing machines are single tanks or two tanks, (3) the length of the dishwashing period, and (4) the length of the meal period—are known, the tables given in the book will aid in the selection of the correct size of water heater.

Steam timetable

Food is prepared for steaming much the same as for boiling. One of the great advantages is that many foods can be cooked in cafeteria inset pans and transferred directly to serving stations without additional handling.

One manufacturer has prepared a steam preparation timetable that lists suggested cooking times for 36 food items. (8D-3)* The small wall chart also lists about 10 preparation suggestions.

For diet cheaters

Probably nothing is as effective in emphasizing the dangers of poor dietary habits as a picture of what such habits can bring about. And when the picture can be humorous, it becomes even more effective.

A pharmaceutical manufacturer has used this idea in an entertaining yet useful way. This company, through excellent use of color photography, produced eight posters showing what people might look like if they were made of the foods they overeat. Names have been given the five men and three women so depicted.

For example, there is Mr. Beeler, the between-mealer, whose clothes are made of chocolate bars and gumdrops and whose skin looks

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MR. BEELER
(The between-mealer)

suspiciously like the peanuts he eats so often. His hair is white—with popcorn. He has pretzel ears, a frankfurter nose and marshmallow eyes. The pupils are hard candy. (See picture.)

Mr. Moss, the meat and potato man, has potato arms and hands,

A forceful approach..

... is required to beat inflation. The first and most important step is to set up records that will measure the effectiveness of control programs.

"Food Cost Accounting"...

... is a manual written especially for the small hospital (and equally useful for the large hospital for charting day-to-day costs). It can be used as the guide for setting up those necessary records. Dietitians or other food service authorities in Association member hospitals may order copies ($1.00 each) from the:

AMERICAN HOSPITAL ASSOCIATION

18 East Division Street, Chicago 10, Illinois

Master Menus for September

The September series of the American Hospital Association's Master Menu is printed on the following pages.

These menus reduce to a minimum the number of diets, simplify planning, decrease costs and conserve food preparation time. The general diet forms the basis of the seven most commonly used special hospital diets. Selections to be served on the general diet are set in boldface type in the Master Menus.

Special diets in the menu plan are the soft, full liquid, high protein, high calorie, low calorie, low fat and measured or weighed. All except the full liquid diet have been planned to include the nine food essentials and servings required for nutritional adequacy. The menus are adaptable for selective service.

New Master Menu kits containing the revised wall cards, sample transfer slips and the "Master Menu Diet Manual" are being mailed to all institutional members of the American Hospital Association. Other hospitals may receive a Master Menu kit, free of charge until September 15, 1951, by writing the Editorial Department of HOSPITALS. After September 15, there will be a small charge for the kits.

September menus are on the following pages.

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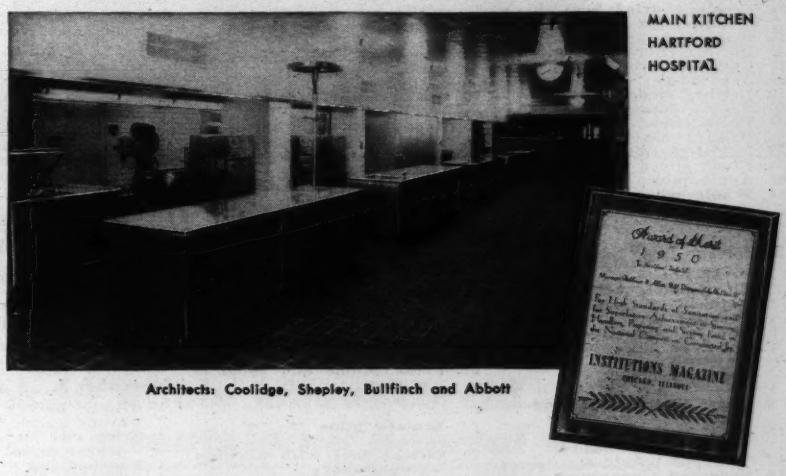
MR. MOSS
(The meat and potato man)

potato eyes and nose, a shoestring potato moustache and hair, a necktie of bacon, and is a genuine meathead. (See picture.) There is plenty of fat in evidence.

Others are Mrs. Sprucer, the miracle reducer; Mr. Weeder, the nico-feeder; Faddist Pearl, the salad girl; Mr. Drencher, the hunger-quencher (via highballs); Sweet-Tooth Bob, the vitamin snob; and Mrs. Peeler, the vitamin stealer.

These posters, which contain no printing except the title, may be used by physicians in illustrating dietary faults. Hospital dietitians and administrators who are interested may learn how to receive free copies of the 11 x 13½-inch posters, in color, by writing the Editorial Department of HOSPITALS, 18 E. Division Street, Chicago 10.



MAIN KITCHEN
HARTFORD
HOSPITAL

Architects: Coolidge, Shepley, Bullfinch and Abbott

VAN-equipped hospital honored for its food service

★ Hartford Hospital, Hartford, won the coveted Merit Award in the Food Service Competition of the Magazine INSTITUTIONS. The Award informs a national audience of the efficiency of this operation.

★ Van takes pride in its part . . . responsibility for design and fabrication of equipment for kitchens, cafeterias, and decentralized food service for this important 16-story hospital.

★ If you require food service equipment improvements, get the benefit of *Van's century of experience.*

The John Van Range Co.

EQUIPMENT FOR THE PREPARATION AND SERVING OF FOOD

DIVISION OF THE EDWARDS MANUFACTURING CO.

Branches in Principal Cities

224-244 EGGLESTON AVENUE **CINCINNATI 2, OHIO**

September 1

1. **Tomato juice**
2. Tomato juice
3. **Puffed rice or granular wheat cereal**
4. **Soft cooked egg**
5. Canadian bacon
6. **Cinnamon apple muffins**

7. **Cream of mushroom soup**
8. **Croutons**
9. **Veal fricassee**
10. Roast veal
11. **Stuffed potatoes au gratin**
12. Noodles
13. **Broccoli**
14. Carrots
15. **Pineapple and orange salad**
16. **Mayonnaise**
17. **Graham cracker custard**
18. Baked custard
19. Cherry gelatin
20. Half grapefruit
21. Blended citrus juice

22. **Alphabet soup**
23. **Saltines**
24. **Creamed dried beef in toast cups**
25. Broiled chopped steak
26. Broiled chopped steak
27. Cubed potatoes
28. **Asparagus**
29. **Lettuce wedge salad**
30. **French dressing**
31. **Fresh sliced peaches**
32. Canned peaches
33. Baked custard
34. Fresh sliced peaches
35. Apple juice
36. **Whole wheat bread**

September 2

1. **Fresh plums**
2. Blended citrus juice
3. **Oatmeal or corn flakes**
4. **Poached egg**
5. Link sausages
6. **Toast**

7. **Cranberry juice**
8. ———
9. **Roast turkey—dressing—gravy**
10. Roast turkey
11. **Whipped potatoes**
12. Whipped potatoes
13. **Peas and mushrooms**
14. Peas
15. **Celery hearts and radishes**
16. ———
17. **Black raspberry ice cream**
18. Vanilla ice cream
19. Raspberry ice
20. Honeydew melon
21. Orange juice or beef bouillon

22. **Tomato bouillon**
23. **Whole wheat wafers**
24. **Baked cheese sandwich**
25. Crisp bacon
26. Lamb chop
27. Parsley potato balls
28. **Green beans**
29. **Apple, orange and grape salad**
30. **Mayonnaise**
31. **Chocolate pudding with meringue topping**
32. Canned Royal Anne cherries
33. Chocolate pudding
34. Unsweetened canned Royal Anne cherries
35. Pineapple juice
36. ———

September 3

1. **Orange juice**
2. Orange juice
3. **Crisp oat cereal or farina**
4. **Scrambled egg**
5. Bacon
6. **Raisin toast**

7. **Consomme**
8. **Melba toast**
9. **Beef pie with biscuit topping**
10. Broiled beef pattie
11. ———
12. Riced potatoes
13. **Sliced beets**
14. Sliced beets
15. **Mixed fresh fruit salad**
16. **Fluffy cooked dressing**
17. **White cake with caramel icing**
18. Plain cake with lemon sauce
19. Lemon and lime gelatin cubes
20. Fresh pear
21. Grapefruit juice

22. **Cream of asparagus soup**
23. **Saltines**
24. **Cold sliced ham—potato salad**
25. Cold sliced turkey—spinach with lemon
26. Cold sliced turkey—spinach with lemon
27. Baked potatoes
28. ———
29. **Relishes—cucumber slices, carrot sticks and pickles**
30. ———
31. **Prune whip**
32. Prune whip
33. Baked custard
34. Unsweetened canned apricots
35. Limeade
36. **Cloverleaf rolls**

September 4

1. **Sliced bananas**
2. Apricot nectar
3. **Rolled wheat or puffed rice**
4. **Poached egg**
5. Grilled ham
6. **Coffee cake**

7. **Beef broth with barley**
8. **Toast sticks**
9. **Creole liver**
10. Baked liver
11. **Parslied potatoes**
12. Parslied potatoes
13. **Lima beans**
14. Wax beans
15. **Cottage cheese, chopped olive and nut balls on lettuce**
16. ———
17. **Fresh plums and seedless grapes**
18. Strawberry Bavarian cream
19. Orange ice
20. Fresh plums and seedless grapes
21. Limeade

22. **Tomato juice**
23. ———
24. **Salmon loaf with pimento cream sauce**
25. Hot minced beef
26. Cold roast beef
27. Cubed potatoes
28. **Green peas**
29. **Jellied vegetable salad**
30. **Mayonnaise**
31. **Lemon delicious pudding**
32. Canned peeled apricots
33. Vanilla ice cream
34. Orange sections
35. Beef bouillon
36. **Butterhorn rolls**

September 5

1. **Grapefruit juice**
2. Grapefruit juice
3. **Wheat flakes or oatmeal**
4. **Soft cooked egg**
5. Bacon
6. **Blueberry muffins**

7. **Cream of celery soup**
8. **Toasted crackers**
9. **Roast pork—spiced crab apple**
10. Roast lamb
11. **Scalloped potatoes**
12. Potato balls
13. **Acorn squash**
14. Acorn squash
15. **Head lettuce salad**
16. **Thousand Island dressing**
17. **Peppermint ice cream**
18. Peppermint ice cream
19. Strawberry gelatin
20. Unsweetened canned bing cherries
21. Orange juice

22. **Beef bouillon**
23. **Saltines**
24. **Eggs a la king on rusk**
25. Creamed eggs on rusk
26. Baked veal pattie
27. Baked potatoes
28. **Asparagus**
29. **Sliced tomato and cucumber salad**
30. **Celery seed French dressing**
31. **Baked apple**
32. Fresh applesauce
33. Floating island
34. Unsweetened baked apple
35. Peach nectar
36. **Whole wheat bread**

September 6

1. **Honeydew melon**
2. Blended citrus juice
3. **Farina or wheat and barley kernels**
4. **Scrambled egg**
5. Canadian bacon
6. **Toast**

7. **French onion soup**
8. **Cheese sticks**
9. **Hamburger pattie with mushroom sauce**
10. Roast beef
11. **Oven browned potatoes**
12. Whipped potatoes
13. **Glazed carrots**
14. Sliced carrots
15. **Fruited lime gelatin with bananas, nuts and orange salad**
16. **Mayonnaise**
17. **Floating island**
18. Floating island
19. Raspberry ice
20. Unsweetened canned boysenberries
21. Lemonade

22. **Cranberry juice cocktail**
23. ———
24. **Chicken and rice casserole**
25. Chicken and rice casserole—spinach with lemon
26. Hot sliced chicken—spinach with lemon
27. Steamed rice (omit on Soft Diet)
28. ———
29. **Shredded cabbage and green pepper salad**
30. **French dressing**
31. **Ginger bread with lemon sauce**
32. Canned pears
33. Vanilla blanc mange
34. Half grapefruit
35. Beef bouillon
36. **Whole wheat rolls**

September 7

1. **Orange halves**
2. Orange juice
3. **Crisp rice or granular wheat cereal**
4. **Poached egg**
5. Country sausage
6. **Plain muffins**

7. **Vegetable soup**
8. **Whole wheat wafers**
9. **Fried scallops — tartar sauce**
10. Baked haddock
11. **Creamed potatoes**
12. Cubed potatoes
13. **Sliced beets**
14. Sliced beets
15. **Tossed vegetable salad**
16. **Clear French dressing**
17. **Frozen boysenberries — coconut macaroons**
18. Prune whip
19. Cherry gelatin
20. Tokay grapes
21. Grapefruit juice

22. **Chicken noodle soup**
23. **Toasted crackers**
24. **Cold plate—cottage cheese on lettuce, sliced tomatoes, celery curls and olives**
25. Cottage cheese
26. Cottage cheese—sliced tomatoes—celery curls
27. Paprika potatoes
28. **Green beans**
29. ———
30. ———
31. **Cherry roll**
32. Canned fruit cup
33. Baked custard
34. Unsweetened canned Royal Anne cherries
35. Apricot nectar
36. **French bread**

September 8

1. **Tomato juice**
2. Tomato juice
3. **Rolled wheat or corn flakes**
4. **Scrambled egg**
5. Bacon
6. **Raisin toast**

7. **Split pea soup**
8. **Croutons**
9. **Ham a la king on toast points**
10. Lamb chop
11. **Baked potatoes**
12. Baked potatoes
13. **Spinach with lemon**
14. Spinach with lemon
15. **Pear and macaroon crumb salad**
16. **Mayonnaise**
17. **Lemon meringue pie**
18. Lemon pudding
19. Orange ice
20. Honeydew melon
21. Limeade

22. **Consomme**
23. **Toast sticks**
24. **Spaghetti with meat balls**
25. Broiled beef pattie
26. Broiled beef pattie
27. Spaghetti and tomato puree
28. **Peas**
29. **Lettuce wedge salad**
30. **Russian dressing**
31. **Fresh sliced peaches**
32. Pineapple juice whip
33. Vanilla ice cream
34. Fresh sliced peaches
35. Orange juice
36. **Hard rolls**

September 9

1. **Grapefruit juice**
2. Grapefruit juice
3. **Raisin bran flakes or farina**
4. **Soft cooked egg**
5. Grilled ham
6. **Toast**

7. **Jellied beef broth**
8. **Melba toast**
9. **Maryland chicken—gravy**
10. Baked chicken
11. **Mashed potatoes**
12. Whipped potatoes
13. **Brussels sprouts**
14. Mashed squash
15. **Cinnamon apple salad**
16. **Whipped cream dressing**
17. **Baked custard**
18. Baked custard
19. Whipped raspberry gelatin
20. Unsweetened canned fruit cocktail
21. Lemonade

22. **Vegetable soup**
23. **Saltines**
24. **Tunafish salad—potato chips**
25. Creamed tunafish
26. Low fat tunafish
27. Parslied potatoes
28. **Sliced carrots**
29. **Relishes—radishes, cucumber slices, pickles**
30. ———
31. **Prune and nut cake**
32. Canned Royal Anne cherries
33. Soft custard
34. Fresh plums
35. Apple juice
36. **Parker House rolls**

September 10

1. **Sliced bananas**
2. Blended citrus juice
3. **Oatmeal or puffed wheat**
4. **Poached egg**
5. Link sausage
6. **Molasses branflake muffins**

7. **Cream of mushroom soup**
8. **Toasted crackers**
9. **Veal loaf—cranberry sauce**
10. Roast veal
11. **Scalloped potatoes**
12. Steamed potatoes in jackets
13. **French style green beans**
14. French style green beans
15. **Diced pineapple, celery and white grape salad**
16. **Mayonnaise**
17. **Chocolate ice cream**
18. Chocolate ice cream
19. Grape sponge
20. Sliced oranges
21. Orange juice

22. **Chicken rice soup**
23. **Melba toast**
24. **Grilled tomato on toast with cheese sauce**
25. Broiled liver
26. Broiled liver
27. Stuffed baked potatoes
28. **Asparagus**
29. **Mixed green salad**
30. **Chiffonade dressing**
31. **Orange and seedless grape cup**
32. Canned peaches

Soft Bulk Diets Call for PETTIJOHNS

...the hot, flaked whole wheat cereal *containing natural bran*

When safe, gentle bulk is a necessary part of special diets, remember to include Pettijohns.

Pettijohns is one of the most important single foods in soft-bulk diets. For here is warm, moist bran in its *natural* form . . . blended into a nutritious whole wheat cereal that contains whole grain food values of protein, minerals and B vitamins. A single serving (1 ounce, dry weight of Pettijohns, with sugar and four ounces of milk) makes the following contribution to the minimum daily adult requirements:

Thiamin	16.20%
Riboflavin	11.60%
Iron	11.60%
Calcium	19.20%
Phosphorus	28.00%

You'll find Pettijohns is a favorite with your patients. Even the most listless appetites respond to its tempting nut-sweet flavor and flaky, whole-grain texture.

Cooks to perfection in less than five minutes . . . costs less than a cent a serving. Serve Pettijohns regularly—ideal for soft-bulk diets.

Soft-Bulk Diets Need *VARIETY*, too!
Try these delicious Pettijohns Cookies

Another in the new series of Quantity Recipes prepared for dietitians by the Quaker Oats Institutional Test Kitchen.

If you are not receiving these recipes, please write Mary Alden, Institutional Test Kitchen, The Quaker Oats Co., Chicago 54.

PETTIJOHNS COOKIES

Cookies — 200 two-inch cookies

Portion: 2 cookies — Total Weight of Dough: 5 lb. 12 oz.

INGREDIENTS	AMOUNT	WEIGHT	COST
Flour, sifted	1 quart	1 lb.	
Soda	1½ teaspoons		
Salt	2 teaspoons		
Ginger	2 teaspoons		
Cinnamon	1 tablespoon		
Shortening	1½ cups	12 oz.	
Sugar	3 cups	1½ lb.	
Eggs	3 eggs	5 oz. (K.P.)	
Molasses	½ cup		
Water	½ cup		
Pettijohns Rolled Wheat	1 quart	12 oz.	
Raisins	1 pint	15 oz.	

Directions

1. Sift together flour, soda, salt and spices into mixer bowl. Add shortening, sugar, eggs and molasses. Beat at low speed until smooth, about 1 minute.
2. Add water, rolled wheat and raisins. Beat at low speed only until blended, about 15 seconds.
3. Drop from a teaspoon onto greased baking sheet and bake in a moderate oven (350°F.) 12 to 15 minutes.

PETTIJOHNS COOKIES — THE QUAKER OATS COMPANY INSTITUTIONAL KITCHEN

33. Snow pudding with custard sauce
34. Orange sections
35. Peach nectar
36. **Whole wheat bread**

September 11

1. **Fresh pear**
2. Prune juice with lemon
3. **Corn flakes or granular wheat cereal**
4. **Scrambled egg** (omit on Low Fat Diet)
5. Bacon
6. **Toast**

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7. **Scotch broth**
8. **Whole wheat crackers**
9. **Cubed steak**
10. Broiled steak
11. **Mashed potatoes**
12. Whipped potatoes
13. **Cauliflower**
14. Beets
15. **Tomato, green pepper and celery salad**
16. **Thousand Island dressing**
17. **Blueberry tarts**
18. Peppermint tapioca
19. Lemon ice
20. Seedless grapes
21. Blended citrus juice

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22. **Cream of asparagus soup**
23. **Saltines**
24. **Baked eggs in bacon rings**
25. Baked eggs in bacon rings
26. Baked egg
27. Cubed potatoes
28. **Green peas**
29. **Grapefruit and pimento salad**
30. **French dressing**
31. **Cup cakes with coconut frosting**
32. Fresh applesauce
33. Baked custard
34. Fresh plums
35. Pineapple juice
36. **Butterscotch rolls**

September 12

1. **Orange juice**
2. Orange juice
3. **Farina or shredded wheat**
4. **Soft cooked egg**
5. Canadian bacon
6. **Coffee cake**

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7. **Alphabet soup**
8. **Toast sticks**
9. **Chicken croquettes—cream sauce with peas**
10. Stewed chicken
11. **Steamed rice**
12. Steamed rice
13. **Savory carrots with onions and celery**
14. Carrots
15. **Head lettuce salad**
16. **Celery seed dressing**
17. **Pineapple ice**
18. Vanilla ice cream
19. Strawberry gelatin
20. Unsweetened canned blackberries
21. Grapefruit juice

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22. **Vegetable soup**
23. **Crackers**
24. **Scalloped potatoes and ham**
25. Scalloped potatoes with beef
26. Baked veal chop
27. Potato balls (omit on Soft Diet)
28. **Spinach with lemon**
29. **Apple, orange and fresh pear slices salad**
30. **Mayonnaise**
31. **Lemon sponge pudding**
32. Canned peeled apricots
33. Vanilla ice cream
34. Sliced bananas
35. Limeade
36. **Cheese rolls**

September 13

1. **Fresh plums**
2. Blended citrus juice
3. **Bran flakes or hominy**
4. **Poached egg**
5. Grilled ham
6. **Toast**

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7. **Vegetable juice cocktail**
8. ———
9. **Roast lamb, mint sauce**
10. Roast lamb
11. **Candied sweetpotatoes**
12. Cubed potatoes
13. **Braised celery**
14. **Asparagus**
15. **Apricot and cream cheese balls rolled in nuts on watercress**
16. **Mayonnaise**
17. **Spice cake with seafoam icing**
18. Cottage pudding with lemon sauce
19. Cranberry ice
20. Honeydew melon
21. Orange juice or consomme

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22. **Cream of pea soup**
23. **Saltines**
24. **Barbecued hamburger on bun**
25. Broiled beef pattie—mashed squash
26. Broiled beef pattie—mashed squash
27. Riced potatoes
28. ———
29. **Shredded cabbage salad**
30. **French dressing**
31. **Orange and grapefruit sections cup—chocolate chip cookies**
32. Orange sections
33. Cherry sponge
34. Orange and grapefruit sections
35. Apple juice
36. ———

September 14

1. **Grapefruit juice**
2. Grapefruit juice
3. **Rolled wheat or crisp rice cereal**
4. Scrambled egg (omit on Normal Diet)
5. Bacon
6. **French toast—jelly**

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7. **Cream of celery soup**
8. **Croutons**
9. **Stuffed baked haddock—paprika lemon garnish**
10. Baked haddock
11. **Parslied potatoes**
12. Parslied potatoes
13. **Harvard beets**
14. Spinach
15. **Mixed green salad**
16. **French dressing**
17. **Apple pie**
18. Orange chiffon pudding
19. Whipped cherry gelatin
20. Fresh fruit cup
21. Lemonade

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22. **Tomato juice**
23. ———
24. **Cheese fondue**
25. Cottage cheese
26. Cottage cheese
27. Baked potatoes
28. **Whole green beans**
29. **Lettuce wedge salad with radish garnish**
30. **Chiffonade dressing**
31. **Lemon flake ice cream**
32. Prune whip
33. Floating island
34. Malaga grapes
35. Beef bouillon
36. **Cloverleaf rolls**

September 15

1. **Orange halves**
2. Orange juice
3. **Corn flakes or oatmeal**
4. **Soft cooked egg**
5. Link sausage
6. **Nut muffins**

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7. **Cream of vegetable soup**
8. **Melba toast**
9. **Beef stew**
10. Broiled beef pattie
11. ———
12. Stuffed baked potatoes
13. **Broccoli**
14. Carrots
15. **Cherry perfection salad**
16. **Mayonnaise**
17. **Coconut cream pudding**
18. Vanilla pudding
19. Lemon ice
20. Unsweetened baked apple
21. Blended citrus juice

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22. **Consomme**
23. **Toasted crackers**
24. **Assorted cold cuts—creamed potatoes**
25. Hot veal cubes
26. Hot veal cubes
27. Noodles
28. **Peas**
29. **Tomato and cucumber salad**
30. **Tarragon dressing**
31. **Fresh pear**
32. Canned pear
33. Baked custard
34. Fresh pear
35. Mixed fruit juice
36. **Rye bread**

September 16

1. **Persian melon or cantaloupe**
2. Blended citrus juice
3. **Granular wheat cereal or puffed rice**
4. **Poached egg**
5. Bacon
6. **Toast**

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7. **Cream of corn soup**
8. **Saltines**
9. **Baked ham**
10. Baked veal chop
11. **Mashed sweetpotatoes**
12. Whipped potatoes
13. **Green beans**
14. Green beans
15. **Celery hearts and olives**
16. ———
17. **Vanilla ice cream**
18. Vanilla ice cream
19. Lemon snow
20. Fresh plums
21. Limeade

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22. **Tomato bouillon**
23. **Cheese crackers**
24. **Scalloped tuna**
25. Scalloped tuna
26. Low fat tuna
27. Potato balls
28. **Sliced beets**
29. **Endive and grapefruit sections salad**
30. **French dressing**
31. **Whipped raspberry gelatin**
32. Whipped raspberry gelatin
33. Chocolate pudding
34. Unsweetened canned bing cherries
35. Pineapple juice
36. **Whole wheat rolls**

September 17

1. **Orange juice**
2. Orange juice
3. **Wheat flakes or farina**
4. **Soft cooked egg**
5. Country sausage
6. **Toast**

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7. **Vegetable soup**
8. **Toast sticks**
9. **Liver and bacon**
10. Broiled liver
11. **Scalloped potatoes**
12. Baked potatoes
13. **Julienne carrots**
14. Julienne carrots
15. **Lettuce wedge salad**
16. **Thousand Island dressing**
17. **Pineapple chiffon pie**
18. Assorted gelatin cubes, custard sauce
19. Assorted gelatin cubes
20. Unsweetened canned fruit cocktail
21. Grapefruit juice

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22. **Cream of potato soup**
23. **Saltines**
24. **Ribbon sandwiches — ground ham spread, cream cheese and chopped olives**
25. Pear and cottage cheese salad
26. Broiled beef pattie
27. Quartered steamed potatoes
28. **Asparagus**
29. **Fresh pear slices, bing cherries and melon cube salad**
30. **Whipped cream dressing**
31. **Fudge cake with mocha icing**
32. Orange sections
33. Grape sponge
34. Orange sections
35. Apple juice
36. ———

September 18

1. **Grapefruit juice**
2. Grapefruit juice
3. **Oatmeal or corn flakes**
4. **Scrambled egg** (omit on Low Fat Diet)
5. Canadian bacon
6. **Date muffins**

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7. **Consomme**
8. **Melba toast**
9. **Chicken fricassee—cranberry jelly**
10. Hot sliced chicken
11. **Mashed potatoes**
12. Whipped potatoes
13. **Cauliflower**
14. Peas
15. ———
16. ———
17. **Meringues topped with frozen peach slices**
18. Butterscotch pudding
19. Orange ice
20. Honeydew melon
21. Lemonade

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22. **Cream of mushroom soup**
23. **Crackers**
24. **Link sausage—fried apples**
25. Creamed hard cooked eggs on toast
26. Plain omelet
27. Parslied potatoes
28. **Green beans**
29. **Raw spinach with carrot flowers and chopped celery salad**
30. **French dressing**
31. **Tapioca cream**
32. Canned peaches
33. Baked custard
34. Seedless grapes
35. Apricot nectar
36. **French bread**

September 19

1. **Orange juice**
2. Orange juice
3. **Bran flakes or hominy**
4. Poached egg (omit on Normal Diet)
5. Grilled ham
6. **French toast—jelly**

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7. **Cream of spinach soup**
8. **Croutons**
9. **Baked veal pattie**
10. Baked veal pattie
11. **Creamed cubed potatoes**
12. Boiled potatoes
13. **Mixed vegetables**
14. Latticed beets
15. **Banana and nut salad**
16. **Mayonnaise**
17. **Lemon sherbet**
18. Lemon sherbet
19. Assorted gelatin cubes
20. Half grapefruit
21. Blended citrus juice

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22. **Vegetable soup**
23. **Saltines**
24. **Stuffed baked potatoes with cheese topping—hard cooked egg halves**
25. Lamb chop
26. Lamb chop
27. Stuffed baked potatoes
28. **Carrots**
29. **Apple, pineapple and Tokay grape salad** (unsweetened pineapple for Low Calorie and Weighed Diets)
30. **Chantilly dressing**
31. **Norwegian prune pudding**
32. Fresh applesauce
33. Vanilla ice cream
34. Unsweetened canned blackberries
35. Grapeade
36. **Bran muffins**

September 20

1. **Tomato juice**
2. Tomato juice
3. **Rolled wheat or crisp rice cereal**
4. **Soft cooked egg**
5. Bacon
6. **Graham muffins**

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7. **Beef broth with julienne vegetables**
8. **Whole wheat wafers**
9. **Roast beef—gravy**
10. Roast beef
11. **Browned potatoes**
12. Whipped potatoes
13. **Lima beans**
14. Wax beans
15. **Cucumber, radish and green pepper on watercress**
16. **French dressing**
17. **Dutch apple cake**
18. Apricot Bavarian cream
19. Lemon ice
20. Unsweetened canned peaches
21. Lemonade

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22. **Cream of celery soup**
23. **Toast sticks**
24. **Cold sliced ham—cucumber pickle slices**
25. Cold sliced chicken
26. Cold sliced chicken
27. Steamed rice
28. **Peas**

For your house formula use Carnation... the milk every doctor knows

Carnation is an especially suitable milk for infant feeding, and for bland and special diets. It bears the seal of acceptance of the Council on Foods and Nutrition of the American Medical Association.

"from contented cows"

Laboratory and clinic tests prove that evaporated milk is not only more nourishing, safer, and more digestible for babies... it is also more economical for hospitals than any other form of whole milk, or any infant feeding "compound". No wonder recent surveys show that 80% of the hospitals that have a house formula use evaporated milk for infant feeding!

And out of the hundreds of brands of evaporated milk, Carnation is *one* that every doctor knows... *one* that has been selected by America's leading hospitals. Ask the doctors on your staff about these outstanding characteristics of Carnation that have made it a favorite for more than half a century:

1. Carnation Research Has Improved the Raw Milk Supply

For years, champion cattle from the famous Carnation Farm have been distributed to dairy farmers all over the country, thus improving the local milk supply to the Carnation evaporating plants.

2. Carnation Accepts Only Top-Quality Milk for Processing

Carnation Field Men regularly check the farmer's herds, sanitary conditions of the farm, and equipment. Milk is rejected if it fails to meet any single one of Carnation's high standards.

3. Carnation Processes All the Milk Sold Under the Carnation Label

From cow to can, Carnation Milk is under Carnation's *own* continuous control. It is processed in Carnation's *own* plants with "prescription accuracy" to insure uniformity of milk solid content, curd tension, viscosity and *quality*. Carnation never has—and never will—sell milk processed by another company.

4. Carnation Quality Control Continues Even AFTER the Milk Leaves the Plant

Every can of Carnation bears a control code number ... so that Carnation representatives can check stocks regularly after they're shipped, to be sure hospitals (and mothers) receive fresh, quality milk.

No matter what kind of milk you are now using, you should investigate the advantages of Carnation Evaporated Milk for your house formula. Carnation is unusually simple to prepare—works equally well with terminal heat or standard technique... with pressure or non-pressure terminal heating equipment. Order a supply of Carnation Milk today, and mail the coupon below for free maternity ward material.

Mail This Coupon Today

CARNATION COMPANY
Dept. HL-81
Los Angeles 36, Calif.

Please send me—free of any cost or obligation—a supply of crib cards, formula cards, and baby care leaflets, for use in our hospital.

NAME_____

POSITION_____

HOSPITAL_____

ADDRESS_____

CITY_____ ZONE____ STATE_____

29. **Grapefruit and orange section salad**
30. **Mayonnaise**
31. **Baked custard**
32. Canned peeled apricots
33. Baked custard
34. Unsweetened baked apple
35. Limeade
36. **Parker House rolls**

September 21

1. **Grapes**
2. Grapefruit juice
3. **Corn flakes or granular wheat cereal**
4. **Scrambled egg**
5. Link sausage
6. **Raisin toast**

7. **Cream of pea soup**
8. **Saltines**
9. **Cod fillets a la creole**
10. Baked cod
11. **Baked potatoes**
12. Baked potatoes
13. **Spinach with lemon**
14. Spinach with lemon
15. **Celery hearts and stuffed olives**
16. ———
17. **Cherry cobbler**
18. Cherry tapioca
19. Strawberry gelatin
20. Sliced oranges
21. Orange juice

22. **Tomato juice**
23. ———
24. **Asparagus with cheese sauce on toast**
25. Asparagus with cheese sauce on toast
26. Cottage cheese—asparagus
27. Cubed potatoes
28. ———
29. **Melon ball salad**
30. **Fruit salad dressing**
31. **Old fashioned bread pudding with raisins**
32. Canned Royal Anne cherries
33. Vanilla blanc mange
34. Fresh pear
35. Beef bouillon
36. **Whole wheat bread**

September 22

1. **Banana**
2. Apricot nectar with lime juice
3. **Farina or shredded wheat**
4. **Poached egg**
5. Bacon
6. **Coffee cake**

7. **Beef bouillon**
8. **Toast sticks**
9. **Corned beef**
10. Roast lamb
11. **Boiled potatoes**
12. Boiled potatoes
13. **Cabbage wedge**
14. Sliced carrots
15. **Peach stuffed with apple, orange and pecans**
16. **Mayonnaise**
17. **Chocolate sundae**
18. Vanilla ice cream
19. Orange ice
20. Unsweetened baked apple
21. Grapefruit juice

22. **Cream of chicken soup**
23. **Crackers**
24. **Deviled eggs and tomato salad—potato chips**
25. Scrambled eggs
26. Baked veal chop—sliced tomatoes
27. Noodles
28. **French style green beans**
29. ———
30. ———
31. **Pineapple nut torte with whipped cream**
32. Canned pears
33. Snow pudding with custard sauce
34. Fresh plums
35. Mixed fruit juice
36. **Butterhorn rolls**

September 23

1. **Fresh pear**
2. Blended citrus juice
3. **Puffed rice or rolled wheat**
4. **Soft cooked egg**
5. Canadian bacon
6. **Toast**

7. **Consomme**
8. **Saltines**
9. **Turkey a la king in pattie shells**
10. Stewed chicken
11. **Mashed potatoes**
12. Whipped potatoes
13. **Baked Hubbard squash**
14. Baked Hubbard squash
15. **Head lettuce salad**
16. **Thick French dressing**
17. **Sliced oranges and coconut**
18. Raspberry gelatin cubes with custard sauce
19. Raspberry gelatin
20. Seedless grapes
21. Limeade

22. **French onion soup**
23. **Cheese sticks**
24. **Meat loaf, tomato sauce**
25. Broiled beef pattie
26. Broiled beef pattie
27. Baked potatoes
28. **Green peas**
29. **Cabbage, carrot and green pepper salad**
30. **Tarragon dressing**
31. **Floating island**
32. Orange sections
33. Floating island
34. Half grapefruit
35. Peach nectar
36. **Plain muffins**

September 24

1. **Orange juice**
2. Orange juice
3. **Oatmeal or wheat flakes**
4. **Scrambled egg**
5. Bacon
6. **Toast**

7. **Cream of asparagus soup**
8. **Melba toast**
9. **Baked pork chops**
10. Roast beef
11. **Glazed sweetpotatoes**
12. Baked potatoes
13. **Broccoli**
14. Fresh spinach
15. **Pineapple and cucumber jelly salad**
16. **Mayonnaise**
17. **Prune whip**
18. Prune whip
19. Lemon ice
20. Unsweetened canned apricots
21. Grapefruit juice

22. **Beef bouillon**
23. **Saltines**
24. **Spaghetti with sliced frankfurter**
25. Chicken livers — crisp bacon—asparagus
26. Chicken livers—asparagus —grilled tomato slice
27. Riced potatoes
28. ———
29. **Mixed green salad**
30. **Russian dressing**
31. **Lemon cake pudding**
32. Canned peaches
33. Vanilla ice cream
34. Sliced bananas
35. Pineapple juice
36. **Hard rolls**

September 25

1. **Grapefruit juice**
2. Grapefruit juice
3. **Crisp oat cereal or hominy**
4. **Poached egg**
5. Link sausage
6. **Pecan rolls**

7. **Turkey rice soup**
8. **Saltines**
9. **Lamb stew with green beans**
10. Roast lamb
11. **Parslied potatoes**
12. Parslied potatoes
13. **Whole kernel corn**
14. Carrots
15. **Pear and paprika cottage cheese salad**
16. **Mayonnaise**
17. **Frozen rhubarb or raspberry pie**
18. Chocolate pudding
19. Grape sponge
20. Fresh plums
21. Blended citrus juice

22. **Consomme**
23. **Toasted crackers**
24. **Salmon croquettes, cream sauce**
25. Creamed salmon on toast
26. Cold sliced chicken
27. Potato balls
28. **Green beans**
29. **Sliced tomato salad**
30. **French dressing**
31. **Jellied fruit**
32. Jellied canned fruit
33. Baked custard
34. Unsweetened canned fruit cocktail
35. Apple juice
36. **French bread**

September 26

1. **Honeydew melon**
2. Orange juice
3. **Granular wheat cereal or crisp rice cereal**
4. **Scrambled egg**
5. Grilled ham
6. **Toast**

7. **Vegetable soup**
8. **Melba toast**
9. **Swiss steak**
10. Broiled beef pattie
11. **Mashed potatoes**
12. Whipped potatoes
13. **Brussels sprouts**
14. Asparagus
15. **Apples, celery and Malaga grape salad**
16. **Chantilly dressing**
17. **Peach ice cream**
18. Peach ice cream
19. Raspberry ice
20. Fresh pear
21. Grapefruit juice

22. **Cream of corn soup**
23. **Toast sticks**
24. **Open-faced grilled cheese sandwich with bacon**
25. Cottage cheese
26. Cottage cheese
27. Baked potatoes
28. **Peas**
29. **Grapefruit and green pepper salad**
30. **French dressing**
31. **Cottage pudding with brown sugar sauce**
32. Canned peeled apricots
33. Chocolate ice cream
34. Unsweetened canned boysenberries
35. Lemonade
36. ———

September 27

1. **Tomato juice**
2. Tomato juice
3. **Shredded wheat or oatmeal**
4. **Poached egg**
5. Bacon
6. **Blueberry muffins**

7. **Split pea soup**
8. **Croutons**
9. **Ham loaf with grilled pineapple slice**
10. Baked chicken
11. **Creamed potatoes**
12. Potato balls
13. **Fresh spinach**
14. Fresh spinach
15. **Tossed vegetable salad**
16. **French dressing**
17. **Apricot whip**
18. Apricot whip
19. Orange gelatin
20. Sliced bananas
21. Limeade

22. **Cream of mushroom soup**
23. **Whole wheat crackers**
24. **Beef pie in casserole**
25. Casserole of minced beef with potato topping—carrots
26. Roast beef—carrots
27. Whipped potatoes (omit on Soft Diet)
28. ———
29. **Head lettuce salad**
30. **Celery seed dressing**
31. **Fresh fruit cup**
32. Fresh applesauce
33. Snow pudding with custard sauce
34. Fresh plums
35. Mixed fruit juice
36. **Whole wheat bread**

September 28

1. **Grapes**
2. Blended citrus juice
3. **Rolled wheat or corn flakes**
4. **Soft cooked egg**
5. Canadian bacon
6. **Cinnamon rolls**

7. **Cream of lima bean soup**
8. **Saltines**
9. **Broiled halibut with lemon parsley sauce**
10. Broiled halibut
11. **Au grautin potatoes**
12. Parslied potatoes
13. **Sliced beets**
14. Sliced beets
15. **Perfection salad**
16. **Mayonnaise**
17. **Fresh pear**
18. Floating island
19. Lime ice
20. Unsweetened canned fruit cocktail
21. Orange juice

22. **Vegetable soup**
23. **Toasted crackers**
24. **Creamed hard cooked eggs on toast points**
25. Creamed hard cooked eggs on toast
26. Plain omelet
27. Stuffed baked potatoes
28. **Green beans**
29. **Orange and banana salad**
30. **French dressing**
31. **Gingerbread with whipped cream**
32. Canned Royal Anne cherries
33. Floating island
34. Unsweetened canned Royal Anne cherries
35. Apple juice
36. **Whole wheat bread**

September 29

1. **Grapefruit juice**
2. Grapefruit juice
3. **Wheat flakes or farina**
4. **Poached egg**
5. Grilled ham
6. **Toast**

7. **Cream of potato soup**
8. **Toasted crackers**
9. **Beef heart with rice and tomato sauce**
10. Roast veal
11. ———
12. Cubed potatoes
13. **Green peas**
14. Green peas
15. **Pineapple ring salad topped with melon balls**
16. **Fluffy dressing**
17. **Angel food cake with white icing**
18. Angel food cake
19. Whipped strawberry gelatin
20. Honeydew melon
21. Blended citrus juice

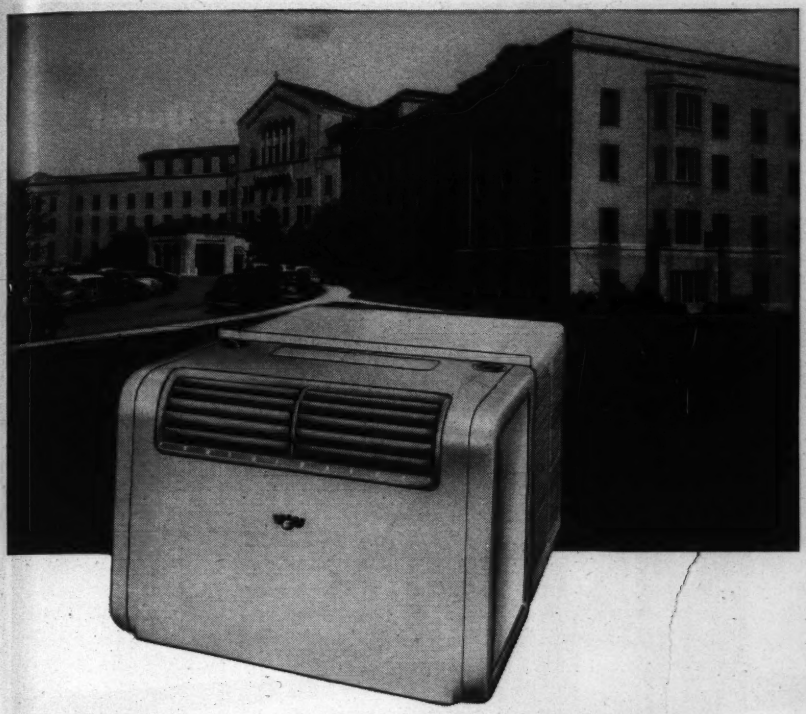
22. **Tomato bouillon**
23. **Saltines**
24. **Hamburger on toasted bun**
25. Broiled beef pattie
26. Broiled beef pattie
27. Potato balls
28. **Mashed squash**
29. **Shredded cabbage salad**
30. **Sour cream dressing**
31. **Apple crisp**
32. Canned pears
33. Vanilla blanc mange
34. Unsweetened baked apple
35. Pineapple juice
36. ———

September 30

1. **Orange halves**
2. Orange juice
3. **Granular wheat cereal or crisp oat cereal**
4. **Scrambled egg**
5. Bacon
6. **Raisin toast**

7. **Chicken bouillon**
8. **Melba toast**
9. **Fried chicken**
10. Hot sliced chicken
11. **Mashed potatoes**
12. Whipped potatoes
13. **Broccoli**
14. Wax beans
15. **Celery heart—radishes**
16. ———
17. **Strawberry sundae**
18. Chocolate sundae
19. Lemon ice
20. Unsweetened canned bing cherries
21. Grapefruit juice

22. **Cream of celery soup**
23. **Croutons**
24. **Canadian bacon—hominy**
25. Crisp bacon
26. Cold sliced veal
27. Baked potatoes
28. **Asparagus**
29. **Apple and grapefruit salad**
30. **Mayonnaise**
31. **Chocolate pudding**
32. Canned peaches
33. Baked custard
34. Fresh pear
35. Grapeade
36. **Nut muffins**



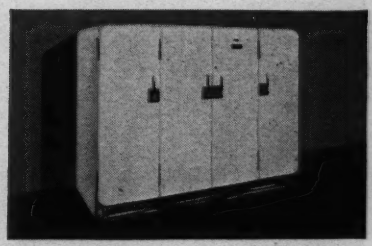
Good Samaritan Hospital Finds Frigidaire Solves Air Conditioning Problem

Maintaining a comfortable temperature in the nursery had always been a problem at the Good Samaritan Hospital, Dayton, Ohio. First, the staff tried fans. Then air was blown over ice to bring relief to the babies and avoid heat rash and fevers on hot, humid days.

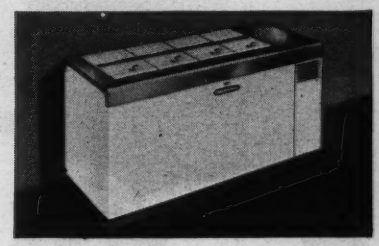
In 1947, three ½ hp Frigidaire Room Air Conditioners were installed in the nursery. Since then, the temperature can be kept at 75°, the humidity between 50% and 60%. And twenty more basinettes have been placed in the same room. The hospital is now using its Frigidaire Conditioners for the fourth consecutive summer.

The Good Samaritan like so many other hospitals has discovered that Frigidaire products always give years of trouble-free service at *really* low operating costs. So whatever your hospital's refrigeration or air conditioning need, call your nearby Frigidaire Dealer or the District Headquarters office that serves you. Look for the name in the Yellow Pages of your phone book under "Refrigeration Equipment." Or write Frigidaire Division of General Motors, Dayton 1, Ohio. In Canada, Leaside (Toronto 17), Ontario. (Ask, too, for Frigidaire's *free* Refrigeration Security Analysis of your refrigeration costs!)

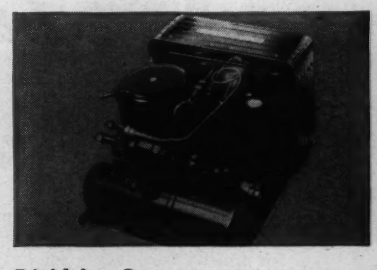
Here are some of the ways Frigidaire can serve your Hospital



Frigidaire Reach-In Refrigerators keep foods fresher longer, cut shrinkage, spoilage to minimum. Sizes range from 17 cu. ft. to 62 cu. ft. models. Models also available with special interiors for safekeeping of biologicals and medicinals.



Frigidaire Low-Temperature Cabinets provide safe cold for frozen foods and ice cream. Ideal for hospital cafeterias and diet kitchens. These cabinets are powered by Frigidaire's famous Meter-Miser compressors, backed by a 5-Year Warranty.



Frigidaire Compressors operate on a trickle of current—save hospitals money. Used with walk-in coolers and in other refrigeration installations. Famous Meter-Miser available in ¼, ⅓, and ½ hp sizes. Reciprocating compressors up to 25 hp.

Other Frigidaire products for hospitals include large self-contained and central system air conditioners, water coolers, beverage coolers and ice makers.

FRIGIDAIRE

Over 400 commercial refrigeration and air conditioning products—most complete line in the industry.

QUIET is "good medicine"

...for your patients! for your staff!

Hundreds of hospitals all over the country have found that job-proved Acousti-Celotex Sound Conditioning is a sound investment that pays double dividends.

First—it protects patients from the disturbing effects of unwanted noise, brings the quiet comfort essential for speedy recovery! Second—it creates the restful environment doctors, nurses and service personnel need for maximum working efficiency!

A sound-absorbing ceiling of Acousti-Celotex Tile instantly quiets routine noises in lobbies, corridors, kitchens, wards, nurseries. Quickly installed at moderate cost! Standard perforated Acousti-Celotex Tile requires no special maintenance—can be painted *repeatedly* and washed without impairing sound-absorbing capacity.

As a member of the world's most experienced Sound Conditioning organization, your local distributor of Acousti-Celotex products can assure you—in advance—the most efficient, most attractive installation possible. He has the broad training and "know-how"—the job-proved methods—the complete line of top quality materials necessary to meet every specification, every requirement, every building code!

FOR A FREE ANALYSIS of your particular noise problem, write now for the name of your local distributor of Acousti-Celotex products. We will also send you a free copy of the informative booklet, "The Quiet Hospital"—on request. Address: The Celotex Corporation, Dept. F-81, 120 S. La Salle St., Chicago 3, Ill. In Canada: Dominion Sound Equipments, Ltd., Montreal, Quebec.

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Sound Conditioning Products

PRODUCTS FOR EVERY SOUND CONDITIONING PROBLEM

THE CELOTEX CORPORATION, 120 S. LA SALLE ST., CHICAGO 3, ILLINOIS

For economy of operation—

maintain what you have

A. F. FRAMPTON

IN THESE DAYS of shortages of materials and of slow deliveries, it becomes more important to keep equipment operating in good order with as little repair and replacement as possible. The best way to do this is to service the equipment regularly and carefully. In other words, establish a good preventive maintenance program. We, at the City Hospital of Akron, have organized a program which can be adapted to almost any size of institution.

Everybody seems to agree that preventive maintenance is very desirable. The board of trustees, the administrator, the various departments of the hospital (the maintenance department in particular) and the patients, all would prefer that trouble be eliminated before it happens.

Certainly the board of trustees would rather know in advance just how much money is to be required for repairs and replacements than to be called upon, unexpectedly, for money to replace some expensive equipment that has been worn out prematurely because of faulty maintenance.

The administrator also would be relieved of much annoyance if he could accurately budget his maintenance expenditures in advance and if the daily routine of the hospital would not be continually upset by poorly maintained systems and equipment. The annoyance caused by faulty equipment and sloppy maintenance can cause dissatisfaction among all personnel.

The maintenance men who must make these unscheduled repairs usually are more upset than those who must use the equipment. The men resent being called from a job to make a rush repair. They can do better work and accomplish more if they can plan their work in advance, get the tools and materials ready, and then stay on the job until the work is finished.

The head of the maintenance department gets a feeling of satisfaction when all the work goes ahead as planned and is uninterrupted by too many emergency calls. An unexpected breakdown usually makes double work for him. He must devise some means of making temporary emergency repairs and then he must plan the permanent repairs.

A patient entering the hospital would have more confidence in the institution if he found clean, comfortable, well maintained buildings and smoothly operating equipment.

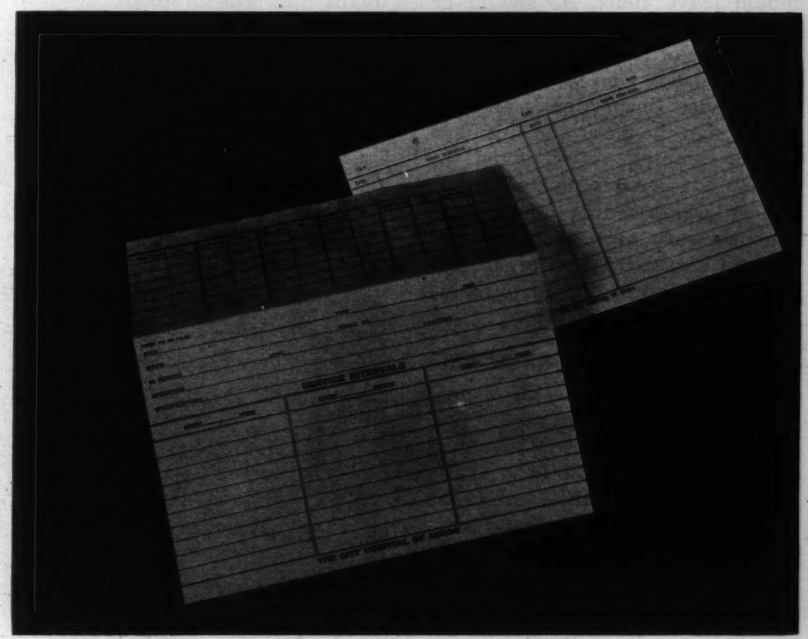
Preventive maintenance is very desirable but it is not accomplished by wishing. It takes a considerable investment in time, thought and money.

Trying to establish a system of preventive maintenance may seem like trying to lift yourself by the bootstraps. The maintenance men are too busy trying to catch up to that stack of orders for emergency repairs to make their scheduled service inspections.

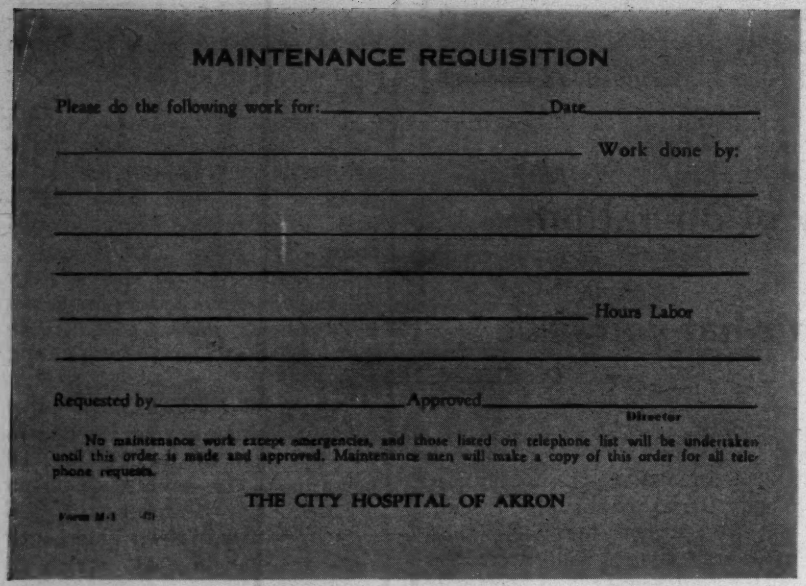
If this is true, then additional help should be provided so that schedules can be maintained. Emergency work should be reduced considerably after the program has been completed, and the force then can again be reduced.

Care should be exercised in the assignment of work. A man should not be assigned to a job unless he is capable of doing it well. He should know that he is expected to make permanent repairs. Some-

MAINTENANCE men should not depend upon memory for servicing information. Daily reference to the forms below will make certain that all machines will be serviced regularly.



Mr. Frampton is the director of maintenance of The City Hospital of Akron, Akron, Ohio. This article is adapted from a paper delivered at the Ohio meetings in April.



MAINTENANCE REQUISITION

Please do the following work for:_____ Date_____

_____ Work done by:

_____

_____

_____

_____ Hours Labor

_____

Requested by_____ Approved_____
Director

No maintenance work except emergencies, and those listed on telephone list will be undertaken until this order is made and approved. Maintenance men will make a copy of this order for all telephone requests.

THE CITY HOSPITAL OF AKRON

Form M-1 -51

WORK order blanks are particularly useful in recording service requests which are received over the telephone. They can also be used by the engineer to check the day's work.

times a man will have the mistaken idea of saving money by patching something together in order to get a little more service out of it. Quite often this is a source of trouble. The men should understand that the best job is the cheapest job in the long run.

Each man should understand just what his duties are and what equipment he is responsible for. He should be taught where his responsibilities end and what he should leave alone. He should be instructed to make reports on any indications of trouble that he finds. He should be given written orders for service inspections, and he should sign the order and turn it in with a complete report when the service has been completed.

Regularly scheduled inspections are necessary and important but without a systematized procedure, one would find it difficult to maintain such schedules.

TYPES OF INSPECTIONS

There are three types of inspections that should be made. The first is a general inspection of the entire premises by the head of the department to make sure that nothing is missed. A second type would be one such as the inspection and repair of all leaking faucets or the inspection and replacement of all faulty lamp cords, pull strings, switches and receptacles. The third type of inspection is concerned with a specific machine and a specified service to the machine.

Memory is not reliable enough for the third type of inspection. A man might remember that suction machines are to be lubricated weekly, but unless the units are numbered and can be checked off as the work is done, a new employee—or even an old one—might miss one of them.

One man might be qualified to lubricate the elevator drives, but he may not be qualified to clean and adjust the electric controls. It is necessary, therefore, to send a qualified man to perform each of these services.

The first step toward systematizing would be in the proper identification of the equipment. Each piece of equipment should be assigned a number, and a permanent tag bearing that number should be attached to the machine. After the equipment is identified and labeled, a two-part filing system has been found to be effective.

FILING SYSTEM

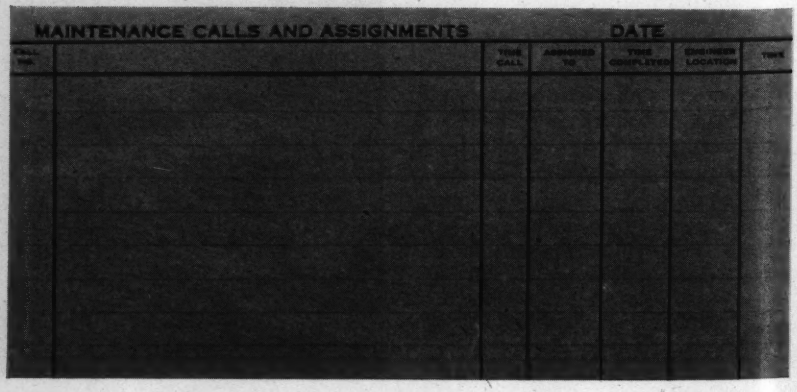
The first is an envelope, filed alphabetically, with the name, number and type of equipment recorded on the outside. The envelope contains all the information concerning the equipment that would be of help in the servicing or repairing of it.

The second part of the filing system is a card file, arranged according to the dates that the equipment is to be serviced. The frequency of each different service required by this particular piece of equipment is marked on the card. When each service has been completed, the card is set up under the date on which the next service is due.

Each day, the person operating the file removes the cards that appear under that date and writes the work orders as called for by the cards. The orders are assigned to the different mechanics as indicated.

The cards should be distributed in the card file, over a definite period so that not too many appear under one date. If this happens, the men will get behind in their work and the cards will ac-

THIS maintenance call and assignment sheet makes it an easy matter to check during the day to see what calls have come in and to see that they have been properly handled.



MAINTENANCE CALLS AND ASSIGNMENTS DATE

CALL NO.		TIME CALL	ASSIGNED TO	TIME COMPLETED	ENGINEER LOCATION	TIME

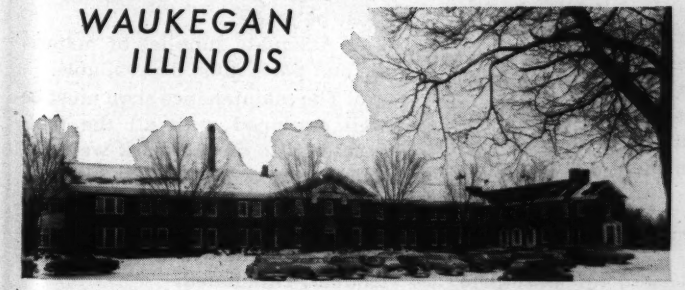
CRANE

the preferred plumbing

FOR PATIENT'S COMFORT

AT VICTORY MEMORIAL HOSPITAL

WAUKEGAN ILLINOIS



• All the conveniences and sanitation of America's *preferred* home plumbing await the convalescent patient at Victory Memorial. Take special note of the Crane *Neuvogue* bathtub—chosen for several de luxe rooms. Although the *Neuvogue* is a full size tub, it measures only 48 inches across. The built-in seat affords comfort and complete safety while foot, sponge or shower bathing. Other fixtures shown here are the Crane *Norwich* lavatory of sanitary vitreous china and the Crane *Walton* closet with efficient siphon jet action. Make selections through your Crane Branch, Crane Wholesaler, or Local Plumbing Contractor.

GANSTER & HENNIGHAUSEN, Waukegan, Ill.
ARCHITECT

HOTHAM & KOETZ, Zion, Ill.
PLUMBING CONTRACTOR

JENKINS & BOLLER, Waukegan, Ill.
GENERAL CONTRACTOR

CRANE CO.

GENERAL OFFICES 836 S MICHIGAN AVE., CHICAGO 5

VALVES • FITTINGS • PIPE
PLUMBING AND HEATING

cumulate. If each day's work is performed on the day it is due, then all the equipment covered by the file will receive regular attention and nothing will be forgotten; the men know just what service is due and will not have to depend on their memories. A comparatively new man will be able to find and service a machine with little chance of overlooking anything.

STOCK ROOM ESSENTIAL

A well supplied stock room, accessible to only one or two men, is essential to good maintenance. All the materials, spare parts and tools should be kept in this stock room. The stock should be arranged so that an inventory of each item can be made easily. Having the necessary materials and parts on hand will save time and in many cases prevent serious damage to a piece of equipment.

If too many people have access to the stock room, shortages are sure to occur. Parts will be used without knowledge of the stock man and as a consequence he will fail to order replacements for them. If the stock man issues all parts and materials himself, he will be better able to see that a sufficient supply is on hand at all times.

The only sure way of having a good supply of tools on hand and in good condition is to keep them in the stock room and issue them in exchange for tool checks. After the tools are returned to the stock room, the stock man should make sure that they are ready for use the next time.

If the hospital is too small to be able to assign a fulltime man to the stock room, it is still possible to hold one man responsible for the stock room along with his other duties.

TELEPHONE CALLS

Another important function that works in very well with the stock room is the taking of telephone calls and the assignment of work. It is essential that all calls for service be recorded and checked off after the work is completed.

If all telephone calls are taken by one man he will be in a position to talk intelligently to the party making the call. He will know what work is in progress, how long it might be until the work can be done, and what questions to ask concerning the nature and location of the trouble. He can tell the mechanic where to go and what tools he might need to do the work.

A special sheet should be provided on which to record all calls. This call and assignment sheet should be laid out in columns—one for the location and nature of the trouble; one for the time the call is received; one for the name of the man assigned to the work, and one for the time of completion. It is then an easy matter to check the sheet during the day to see what calls have come in and to make sure that they have been disposed of properly.

ASSIGNING WORK

After the call has been recorded, it can be written up on a work order blank and assigned to the man who is to do the work.

Care in assigning the work is just as important as careful recording. Too often the order is handed to the first man who enters the shop. Unless the work is extremely urgent, it is better to wait until the qualified man can take care of the work. If the call is urgent, the right man usually can be found by telephone and dispatched from wherever he happens to be.

If an unqualified man is assigned to the job, it may result in a patched job instead of a permanent repair and quite often a second man will have to be sent out in a day or two to make a permanent repair.

Electricians cannot be expected to have much interest in repairing a leaking faucet and neither can a plumber do a good job of adjusting elevator controls.

Careful examination of the call sheets often will show that certain troubles are repeating frequently. A serious attempt should be made to find permanent solutions.

The Engineering and Maintenance department is edited by Roy Hudenburg, secretary of the Council on Hospital Planning and Plant Operation.

Quite often it will be found that these chronic troubles are caused by a system that is inadequate to carry the load placed upon it. In some cases the system may have been designed too small and, in other cases, the hospital may have outgrown the system. It may be that the equipment is just worn out. Examples of this kind might be found in the heating plant, the hot water system, the refrigeration system, the electrical distribution system or in the laundry.

An overloaded electrical system will result in low voltages and fuse troubles. Lighting efficiencies fall off far out of proportion to the drop in voltage. A lamp may draw 95 per cent of its rated power but give less than 80 per cent of its rated light output. Low voltage in a motor will cause it to draw excessive current, and if the condition is severe enough it will cause the motor to burn out.

An overloaded heating system will give smoky, inefficient operation, and boiler maintenance will be excessive. To give satisfactory service and economy of operation, each distribution system must be kept equal to the ever increasing load it is expected to carry.

The steps to be taken to achieve a program of preventive maintenance then, are as follows:

1. It is necessary to have enough qualified men to service and inspect the equipment, to recognize trouble and to make the necessary corrections and recommendations.

2. The men must be organized so that each man knows what his duties are and when they are to be performed.

3. Regularly scheduled servicing and inspections of all equipment must be made.

4. Adequate supplies of materials and parts must be available.

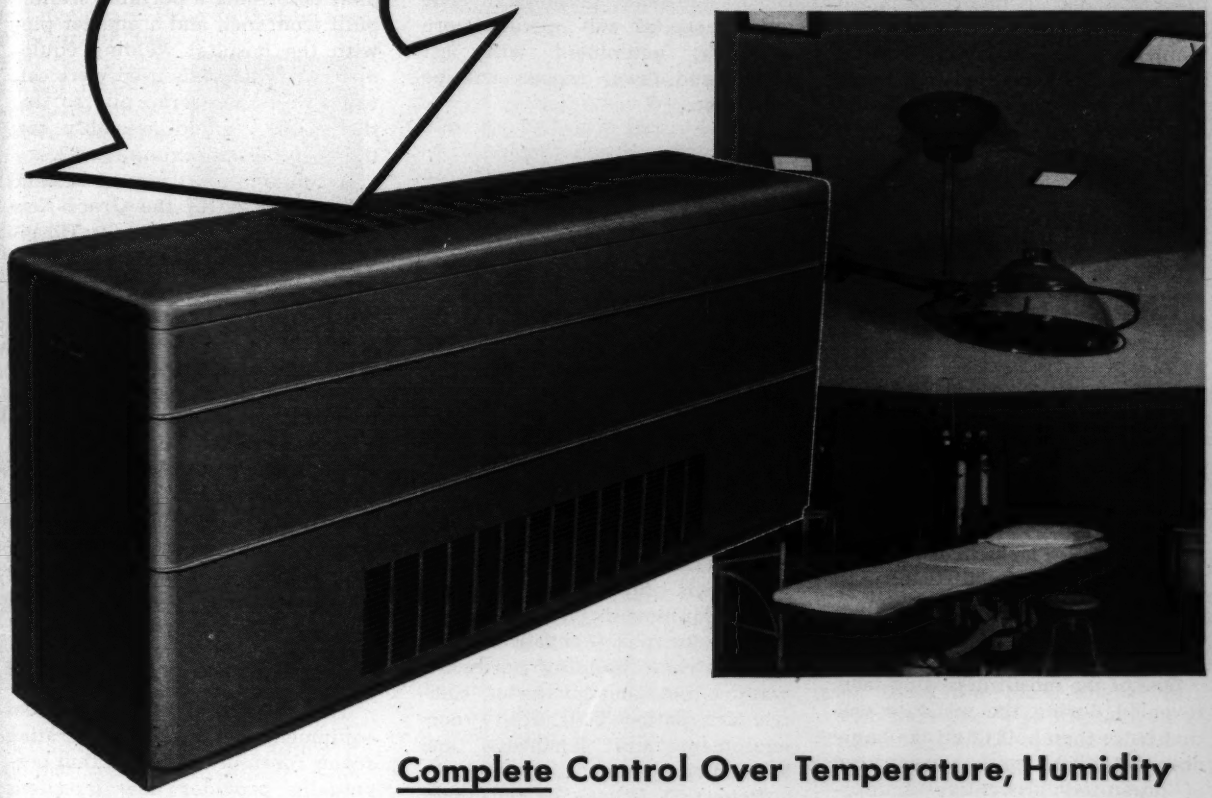
5. The maintenance shop must be well equipped with all the tools necessary to do the work well and quickly.

6. A system of recording trouble calls should be arranged so that they can be analyzed and chronic troubles eliminated.

7. Make sure that all equipment and systems are adequate to do the work that is required of them. Sometimes repeated breakdowns result from demanding more of the

ANOTHER TRANE "FIRST"

OPERATING ROOM AIR CONDITIONER



Complete Control Over Temperature, Humidity

Here's a brand new air conditioner that can bring just-right temperatures and exact humidities into the operating room with complete safety—the new Trane Hospital Operating Room Air Conditioner.

It brings in and conditions outside air for the operating room. It filters the air. It adds moisture or wrings it out of the air to provide correct humidity. It heats or cools the air to the perfect operating room temperature. Then it sends that perfectly-tempered air through the room evenly and quietly.

Created with safety in mind, the unit has spark-proof fans and an explosion-proof motor. All electrical circuits, wiring, switches and fan belt are selected with an eye to safe and trouble-free service. The unit is designed for use in operating rooms regardless of the anesthetic used.

Each Operating Room Air Conditioner has its own control system, so each room has just the conditions it needs just when it needs them. When cooling isn't necessary, the unit can be an efficient source of heating. It will send out warmth in convection currents, without fan or motor.

Trim and compact, the Operating Room Air Conditioner fits snugly under a window. The clean, attractive casing is fully insulated with fiberglass to assure quiet and efficient performance, and the removable front panel means quicker, easier maintenance. Four sizes of the unit, with capacities ranging from 1 to 5 tons of cooling, can meet the needs of virtually any operating room.

For air conditioning that is designed for, and perfectly suited to, operating room needs—see your architect or local Trane representative about the new Trane Hospital Operating Room Air Conditioning Unit.

THE TRANE COMPANY, LA CROSSE, WISCONSIN

Eastern Mfg. Division, Scranton, Pennsylvania
Trane Company of Canada, Ltd. . . . Toronto

OFFICES IN 80 U.S. AND 14 CANADIAN CITIES

TRANE

MANUFACTURING ENGINEERS OF HEATING, VENTILATING AND AIR CONDITIONING EQUIPMENT

system than it was designed to produce.

With a well organized crew of capable, well paid men, who are backed up by a simple, orderly filing system, an ample stock of supplies and parts, plenty of good tools, and an adequate, modernized plant, a hospital can maintain what it has at a final cost that will prove far less than that of an unsatisfactory situation where a "haywire" repair is good enough if it lasts out the day.

Under such an ideal situation, the men are more likely to be happy with their jobs and are likely to be more permanent. The whole hospital will operate more smoothly, equipment will last longer and fewer repairs will be necessary.

ENGINEERING and MAINTENANCE COMMENT

New ideas from Institute

THIS YEAR'S Institute for Hospital Engineers was no exception to the pattern of previous years in the enthusiastic participation of its student group. Held in New York City, June 4-8, it attracted 110 registrants, the largest enrollment since the first institute was held in Chicago in 1948.

One of the most interesting facts revealed during the institute was that more than half of all the engineers attending conduct some kind of organized preventive maintenance program in their plants. Discussion brought out that the greatest stumbling block to the development of comprehensive preventive maintenance programs is the lack of clerical help available to the engineering department. In most instances preventive maintenance programs are limited, but could be much more extensive and fruitful if clerical help was available to keep the records that are the heart of such a program.

Rather startling testimony as to the extent to which maintenance staff can be reduced after a preventive maintenance program has had a real opportunity to produce results was brought to light during the discussion. This would indicate that the investment in one clerical salary offers a tremendous opportunity for financial return through reduced maintenance payroll.

Maintenance trucks: Suggestions for time-saving were submitted by the institute students at a round-table discussion. Several men suggested the provision of a portable cart for the use of one man assigned to preventive maintenance.

W. W. Crump of the Greenville (S.C.) General Hospital stated that his cart is equipped with a vise, hand tools and a variety of supplies. Equipment on the cart is suitable for routine repairs of electric switches, building hardware, water closets and lavatories, electric fans, patient beds, utility room equipment and sterilizers, and kitchen equipment.

Robert D. Wilson of the Johns Hopkins Hospital reports that three carts are in use at that institution.

These carts include one equipped for servicing air conditioning and refrigeration equipment, one equipped with dies, pipe wrenches and other fittings necessary for servicing plumbing, and the third cart completely equipped for either repairing electrical equipment or doing new electrical construction.

Carl H. Zarnke, of the Kitchener-Waterloo Hospital, Kitchener, Ont., Can., reported a similar maintenance truck designed and manufactured in his shop. One particular innovation of the cart is that its standard equipment includes an aluminum tubular ladder, usable either as a stepladder or, when opened full length, as a 10-foot straight ladder. The truck is equipped with many shallow drawers that are designed to accommodate a wide variety of spare parts and fittings.

Ingenious welding: Several months ago this page carried photographs of items that might be made with the use of welding equipment in the hospital shop. We have a letter from Phares B. Riley of the Robeson County (N.C.) Memorial Hospital describing a portable scaffold built from inch and a quarter pipe with the hospital welding equipment. All materials used were salvaged from the scrap pile so that the entire scaffold assembly cost the hospital approximately $2.

A similar report has come from John W. Manz of the Grace-New Haven (Conn.) Community Hospital, who manufactured surgical kick bucket dollies at a substantial saving to the hospital.

Harold S. Moore, administrative engineer of the University of Virginia Hospital, also submitted an excellent suggestion for the institute roundtable. He suggests that the equipment supply room for the hospital be set up near the shop area. This permits the night engineer room crew to keep the stored equipment in top operating conditions through routine servicing and preventive maintenance.

Explosion-proof flashlight

The subject of explosion-proof equipment for hospital operating rooms continues to be one that perpetually provides new questions and new answers. Dorothy Pellenz, chairman of the Safety Committee of the Association, writes that she has found a type of explosion-proof flashlight that is safe to use for operating room staffs in hospitals that do not have the proper emergency lighting systems for their surgeries.

Miss Pellenz has also sent in an announcement for an explosion-proof source of light for ear, nose, and throat procedures. (8E-1)*.

Surgeons who use head-mirrors for directional illumination are accustomed to a goose-neck lamp as the source of illumination. The explosion-proof type of light provides a superior light source and eliminates all of the hazards attendant on the use of the goose-neck lamp.—R. H.

*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

PERSONAL News

RICHARD O. WEST has been appointed administrator of the Norwalk (Conn.) Hospital succeeding DR. JOSEPH P. LEONE, who resigned June 1.

Mr. West has been director of the Salem (Mass.) Hospital for the last five years. Prior to that he was director of the Portsmouth (N.H.) Hospital and assistant director of the New Haven (Conn.) Hospital. He is a graduate of Lafayette College and the school of hospital administration at the University of Chicago. He served his administrative residency at New Haven Hospital.

MR. WEST

Mr. West is a member of the American Hospital Association and a nominee of the American College of Hospital Administrators.

MRS. LEON M. GASKILL, formerly GRACE BARBER, has resigned as administrator of Childrens Memorial Hospital, Omaha, to join her husband in New York.

MILTON B. SHROYER, formerly administrator of the Cumberland Medical Center, Crossville, Tenn., has been appointed assistant administrator in the Knoxville office of the United Mine Workers of America Welfare and Retirement Fund. Previously he had been assistant director of the Oak Ridge (Tenn.) Hospital.

DAVID E. OLSSON has been appointed administrator of San Jose (Calif.) Hospital. He has been acting administrator since the death of WILLIAM P. BUTLER in January.

FREDERIC C. LEROCKER has been chosen as assistant administrator of the hospital. He is a graduate of the University of Minnesota course in hospital administration and served his administrative residency at the Vancouver (B. C.) General Hospital.

The Veterans Administration recently announced several appointments.

DR. EDWARD S. POST, formerly manager of the veterans hospital in Fort Custer, Mich., has been named manager of the veterans hospital in Sheridan, Wyo. He replaces DR. VICTOR H. BEAN, who has been transferred to the Alexandria, La., veterans hospital.

DR. GEORGE S. LITTELL has been appointed manager of the Dallas, Texas, Veterans Administration Hospital. He succeeds DR. FREDERICK R. EASTLAND, who resigned. Dr. Littell has been manager of the veterans hospitals in Wichita, Kan., and Amarillo, Texas.

DR. MORRIS C. THOMAS is to be the new manager of a Veterans Administration hospital soon to be completed in Madison, Wis. He is now manager of the veterans hospital in Waukesha, Wis.

N. A. BRADY, former assistant manager of Queen Mary Veterans Hospital, Montreal, Que., has been appointed manager of the Sunnybrook Hospital, Department of Veterans Affairs, Toronto. Mr. Brady is a member of the American Hospital Association.

FRANKLIN H. SILVERSIDES has been appointed superintendent of the Children's Hospital, Winnipeg, Canada.

Mr. Silversides, who completed the hospital administration course at the University of Toronto, was formerly pharmacist and assistant superintendent of the Children's Hospital.

MR. SILVERSIDES

THOMAS J. GOLDEN, former assistant to the director and a purchasing agent at the Medical Center in Jersey City, N. J., has been appointed administrative director of the city division of the center and is in charge of nonmedical activities of that division.

Mr. Golden is a member of the American Hospital Association and a former treasurer of the New Jersey Hospital Association.

ALDEN B. MILLS, administrator of the Huntington Memorial Hospital, Pasadena, Calif., for the last six years, has been appointed director of the Mountainside Hospital in Montclair, N. J.

MR. MILLS

Mr. Mills is vice president of the Hospital Council of Southern California and was program chairman of the recent western hospital convention in Los Angeles.

A graduate of Reed College, Mr. Mills is a member of the American College of Hospital Administrators.

LESTER TUCK is administrator of the new Felix Long Memorial Hospital, Starkville, Miss. Before his appointment, he was assistant administrative officer of the Mississippi Commission on Hospital Care. He also has been administrator of the Newton County (Miss.) Rural Health Association.

IVOR H. JONES has resigned as assistant director of Newark (N. J.) Beth Israel Hospital to become comptroller of St. Luke's Hospital, Bethlehem, Pa. He is a former comptroller at the Mountainside Hospital, Montclair, N. J.

Mr. Jones has been succeeded at Beth Israel Hospital by GEORGE PECK, former administrator of the Jewish Hospital, Philadelphia.

Mr. Peck spent five years at Michael Reese Hospital, Chicago, as personnel director and later as assistant director.

Both Mr. Jones and Mr. Peck are members of the American Hospital Association.

RAYMOND W. STEM has been appointed administrator of the Warren Hospital, Phillipsburg, N. J.

Mr. Stem was sent to the Hospital Corps School, Brooklyn, while in the Navy during World War II. Until his discharge in 1947, he held

various positions at Navy and Public Health Service hospitals.

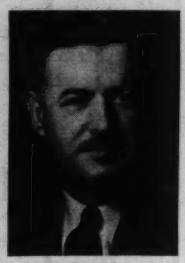
EARL BOURGAIZE, a former assistant administrator of the Temple University Hospital, Philadelphia, has been appointed administrator of the Bound Brook (N. J.) Hospital.

ROBERT L. PARRY has succeeded ROBERT W. POWELL as assistant administrator of Burlington County Hospital, Mount Holly, N. J. Mr. Powell is now administrator of the Burdette Tomlin Memorial Hospital, Cape May Court House, N. J.

DR. GERALD LASALLE has been appointed assistant director of the Royal Victoria Hospital, Montreal.

A graduate of the hospital administration course at the University of Toronto, Dr. LaSalle served his residency at the Royal Victoria Hospital. He is a graduate of University of Montreal and Laval University.

Dr. LaSalle is a member of the American Hospital Association.



DR. LaSALLE

DR. SALVATOR G. MARINO has been appointed superintendent of the Sioux Sanatorium, Rapid City, S. D. He formerly was on the staff of Sunny Acres Tuberculosis Sanatorium, Cleveland.

Dr. Marino was on the medical staff of the Bureau of Indian Affairs at the Rosebud (S. D.) Hospital and was at various other hospitals as tuberculosis specialist and general medical officer in charge of agency health programs.

DR. F. LLOYD MUSSELLS, assistant director of Strong Memorial Hospital of the University of Rochester, New York, has been granted a leave of absence to accept an appointment as deputy executive director of the Committee on Medical Sciences, Research and Development Board, Department of Defense, in Washington, D. C.

Dr. Mussells completed the hospital administration course at Columbia University. He served as postgraduate fellow in hospital administration and later was appointed assistant in hospital administration in the School of Medicine and Dentistry at the University of Rochester.

FRANK E. KIMBLE has been appointed administrator of the new Hardy Wilson Memorial Hospital, Hazlehurst, Miss.

Mr. Kimble formerly was administrator of the Clarksdale (Miss.) Hospital, and for 21 years he was business manager of the Red Cross Hospital in Salida, Colo.

MRS. TRENTON G. SHELTON, R. N., has been appointed administrator of the Covington County Hospital, Collins, Miss. The hospital is scheduled to open this summer. Mrs. Shelton formerly was with the nursing staff of the North Mississippi Community Hospital, Tupelo.

JOSEPH KREYCIK has resigned as administrator of the North Sunflower County Hospital, Ruleville, Miss., to enter Northwestern University as a graduate student in the hospital administration course.

J. B. FRANKLIN, administrator of Tallahassee (Fla.) Memorial Hospital, has retired after 40 years in the hospital administration field.

A life member of the American Hospital Association, Mr. Franklin has served as superintendent of the Texas Baptist Memorial Sanitarium, now Baylor University Hospital, Dallas; director of John D. Archbold Memorial Hospital Thomasville, Ga.; and superintendent of Grady Memorial Hospital, Atlanta, as well as at other hospitals in the South. He is a fellow of the American College of Hospital Administrators.

DR. SOL SHERRY has been appointed director of the May Institute for Medical Research of the Jewish Hospital Association, Cincinnati. He also will be assistant professor in the department of internal medicine at the University of Cincinnati Medical School.

ROBERT B. LLOYD has resigned as administrator of the Texas and Pacific Railway Employees Hospital, Marshall, Texas, to be administrator of St. David's Hospital, Austin.

CLARENCE C. GIBSON has been succeeded as administrator of the Ector County Hospital, Odessa, Texas, by HARRY PAYNE, former administrator of the Houston Tuberculosis Hospital. MAE ALDRICH has been appointed Mr. Payne's successor at the Houston Tuberculosis Hospital.

Mr. Gibson formerly was superintendent of the El Paso (Texas) City-County Hospital and of the Regina (Sask.) General Hospital.

Mr. Payne has served as administrator of the McKinney (Texas) City-County Hospital.

HOWARD ANTHONY has been appointed administrator of the Merced (Calif.) General Hospital replacing R. E. BARNES, who resigned.

Mr. Anthony, who organized a hospital in San Salvador, formerly was administrator of Uvalde (Texas) Memorial Hospital and of Seaside Hospital, Long Beach, Calif.

FREDERICK C. SAGE has been appointed administrator of the Concord (Calif.) Community Hospital, succeeding WILLIAM B. NAPTON, who has been recalled to active duty in the Medical Services Corps of the United States Air Force.

MR. SAGE

Mr. Sage completed the hospital administration course at Columbia University and served his residency at Stanford University Hospital, San Francisco.

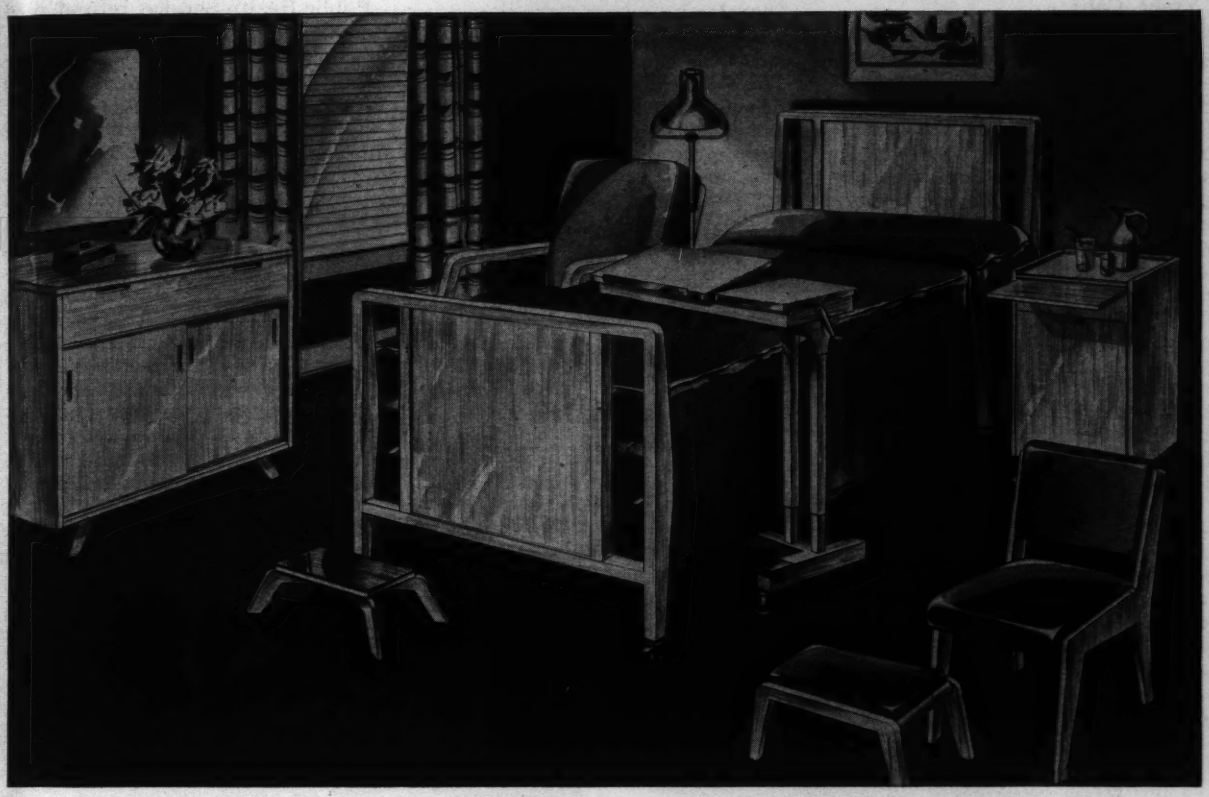
Both Mr. Sage and Mr. Napton are members of the American Hospital Association.

JOHN E. SMITS, former director of the Los Angeles County Harbor General Hospital, Torrance, Calif., has been appointed administrator of the Childrens Hospital, Los Angeles, succeeding HENRY N. WALLACE, who resigned.

ROBERT SANDAHL has been appointed assistant administrator of the Wausau (Wis.) Memorial Hospital succeeding OLIVE M. GRAHAM, R. N., who has been in charge of the hospital since it opened in

Newest design

IN HOSPITAL FURNITURE...



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Smartly-styled to combine the simplicity of clean, functional design with the warmth of real wood, each piece in this new room group incorporates some new feature that results in time saving... greater patient comfort... quicker, easier maintenance... or longer life.

It is superbly constructed of solid birch parts and birch-faced plywood... and is finished in a natural honey color, with matching Formica tops on the chest and cabinet. Its handsome appearance makes this group particularly well suited for use in memorial and other deluxe rooms. And individual pieces blend perfectly with modern steel hospital furniture.

This new line will be exhibited at the forthcoming American Hospital Association Convention in St. Louis. You are cordially invited to stop in at Hard's booth (300-301) and inspect this newest addition to our line of Life-Long products.

Sold exclusively through selected surgical supply dealers.

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1924. She is a member of the American Hospital Association.

ALVIN C. KNAUSS JR., former administrator of Bingham Memorial Hospital, Blackfoot, Idaho, has been appointed manager of the Siskiyou County General Hospital, Yreka, Calif.

Mr. Knauss has directed hospitals in Florida and Oregon and was superintendent of Bay View General Hospital, Palacios, Texas. He is a member of the American Hospital Association.

DR. DAVID CORCORAN, director of the Central Islip (N. Y.) State Hospital since 1933, retired July 31 after 43 years in the state service.

KENNETH D. MOBURG has succeeded JAMES I. BOYCE as administrator of the Schoolcraft Memorial Hospital, Manistique, Mich.

DR. JAMES C. WALSH, superintendent and medical director of the Nassau County Tuberculosis Hospital, Farmingdale, N. Y., will retire September 1. He has served for 25 years as medical director of tuberculosis hospitals.

VERNON D. SEIFERT has been appointed assistant superintendent of the Fairview Park Hospital, Cleveland.

Mr. Seifert formerly was administrative assistant at Evanston (Ill.) Hospital and has served as director of clinics and assistant to the medical director of St. Luke's Hospital, Chicago.

BERTHA DELONG, superintendent of Tobey Hospital, Wareham, Mass., has resigned.

Deaths

ANNA C. WILEY, co-founder and director of Blythewood Sanitarium in Greenwich, Conn., died there July 2.

Mrs. Wiley and her husband, Dr. William Herbert Wiley, who died in 1936, founded the institution about 50 years ago. She directed the institution until six months ago.

LT. COL. NEIL F. MACDONALD, Public Health Service, retired, died suddenly June 5.

Colonel MacDonald was a graduate of the University of Chicago hospital administration course.

COL. MacDONALD

He did private research in hospital administration and management and served as hospital consultant to two Chicago firms and the Public Health Service.

Author of several hospital administration articles, Colonel MacDonald was a member of the American Hospital Association, American College of Hospital Administrators, the Illinois Hospital Association and the Western Hospital Association.

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STANDARD UNIVERSAL HOSPITAL MODEL

This chair was designed especially for use as a fracture chair in the hospital, at home or outdoors. Leg-rests are adjustable for complete comfort of patient. When leg-rests are removed, chair becomes conventional Universal Model. This versatile Wheel Chair weighs only 50 lbs. —easy to handle by attendant or occupant. Folds to 10 inch width, requiring one-third the space of wooden chairs.

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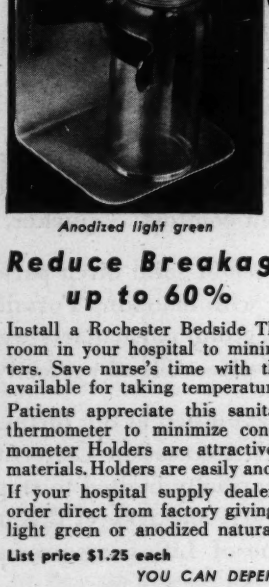
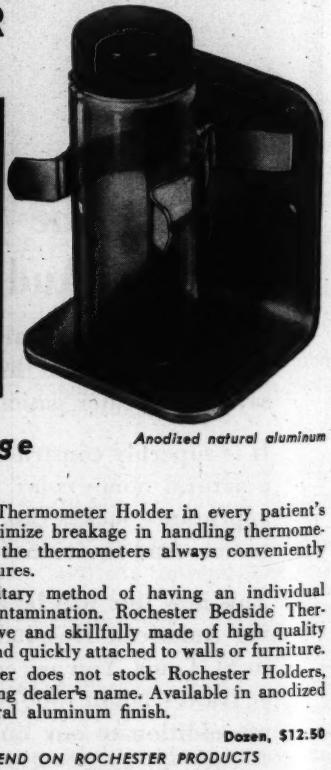


Anodized light green



Anodized natural aluminum

Reduce Breakage up to 60%

Install a Rochester Bedside Thermometer Holder in every patient's room in your hospital to minimize breakage in handling thermometers. Save nurse's time with the thermometers always conveniently available for taking temperatures.

Patients appreciate this sanitary method of having an individual thermometer to minimize contamination. Rochester Bedside Thermometer Holders are attractive and skillfully made of high quality materials. Holders are easily and quickly attached to walls or furniture.

If your hospital supply dealer does not stock Rochester Holders, order direct from factory giving dealer's name. Available in anodized light green or anodized natural aluminum finish.

List price $1.25 each **Dozen, $12.50**

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The President's Cornerstone Speech

This country's hospitals will have close liaison with the huge National Institutes of Health Clinical Center nearing completion on Washington's outskirts, it was stated at cornerstone ceremonies on June 22. In a short talk preceding the main address by President Truman, Dr. W. H. Sebrell, director of The National Institutes of Health, declared:

"Extremely close working relations will be maintained with medical schools, universities and hospitals throughout the country. This will be as much their clinical center as it is ours. It will be a national center for the advancement of national health."

In his cornerstone address, the President promised that the research center will be no "isolated enterprise." He said, "Research scientists from medical schools, private hospitals and other private institutions will come here to share in the work." The center is scheduled for completion late next year and will cost an estimated $40,000,000.

Dr. Charles F. Wilinsky, president, represented the American Hospital Association at the cornerstone-laying exercises. Also in attendance were the Association's Board of Trustees and coordinating committee, both of which were meeting in Washington on the day of the ceremonies. An auxiliary feature of the program was "open house" inspection of the institutes' numerous research laboratories.

The President's Address: President Truman used the cornerstone ceremony at the National Institutes of Health Clinical Center as an opportunity to make a major health speech.

The President, speaking to a rain-soaked crowd of 3,000, said he has not given up his fight for some form of national compulsory health insurance. But he struck a milder note when he said, "I want to make it clear, however, that I am not clinging to any particular plan. What I want is a good workable plan that will enable all Americans to pay for the medical care they need. And I will say here and now that if the people who have been blocking health insurance for five years will come up with a better proposal—or even one that is almost as good—I'll go along with them. I want to get the job done, and I am not concerned in the slightest with pride of authorship."

President Truman emphasized the need for medical and hospital coverage for the 75,000,000 persons he cited as having no health insurance at all. Fewer than 4,000,000, he said, have reasonably complete medical care insurance.

The President devoted much of his address to a recapitulation of the medical progress that has been made in the United States through the efforts of the health professions and the Public Health Service. He offered dramatic comparisons of the health of the nation today and 50 years ago and spoke hopefully of the further progress that will be made with the new facilities of the National Institutes of Health, which are operated by the Public Health Service.

Hospital Benefits for Aged

Three weeks after an announcement by Federal Security Administrator Oscar R. Ewing that he favors government-paid hospital benefits for persons over 65, the Congressional attitude toward the plan appeared to be one of letting it lie until popular sentiment has crystallized. In any event, it is almost certain that committee hearings on the proposal will not be held this year.

The hospitalization insurance plan was announced by Mr. Ewing at a press conference June 25. It extends benefits to persons 65 and over and to dependents of deceased persons insured under old age and survivors provisions of the Social Security Act.

Full cost of the program, estimated at $200,000,000 for the first year of operation, would be borne by payroll deductions without having to increase these deductions or draw upon the treasury for additional funds, according to Mr. Ewing. Its introduction is sorely needed, he explained, because voluntary and commercial hospitalization plans generally withhold membership from persons over 65.

PRESIDENT TRUMAN (right) lays the cornerstone of the new National Institutes of Health Clinical Center at ceremonies at Bethesda, Md., June 22. Onlookers are (from left) Dr. W. H. Sebrell, director, National Institutes of Health; Federal Security Administrator Oscar R. Ewing; the Rev. Bernard Braskamp, chaplain of the House of Representatives; Dr. Leonard A. Scheele, surgeon general, Public Health Service, and John McShain, builder.

"The hospital services which would be provided under the plan," he said "are those services, drugs and appliances which the hospital customarily furnishes its bed patients. Specifically excluded would be any medical care except that generally furnished by hospitals as an essential part of hospital care for bed patients. The program would not cover hospitalization in a tuberculosis or mental institution or services provided by institutions like those which specialize in the care of chronic cases."

Sixty days hospitalization annually is contemplated. Authorization for admittance would be by the patient's physician. Payment for care would be made directly to the hospital out of the insurance fund. Rates and payments "would be determined on a mutually agreed basis which would reimburse the hospital for its reasonable costs incurred for all bed patients occupying semi-private accommodations in such hospital, or its equivalent in the case of hospitals which do not have such accommodations." The hospital would be permitted to make differential charges to beneficiaries who want private rooms.

The program, if authorized by Congress, could not be instituted before 1953. It is estimated that 7,000,000 individuals then will be eligible for benefits. These comprise 5,500,000 who are 65 and older; 1,100,000 children, and about 400,000 mothers.

It is proposed, under the Ewing plan, that the program be administered by state agencies, preferably public health departments. They would act as agents of the federal government in negotiating agreements with hospitals and making payments to them. Payment procedures would be comparable to those adopted by Blue Cross plans, according to the Ewing announcement.

Institute of Pathology

Non-federal hospitals throughout the country have a stake in a construction ceremony conducted in the capital on July 10. It was the ground-breaking for a new home for Armed Forces Institute of Pathology, to be erected on the grounds of the Army Medical Center. The new structure will facilitate the rendering of services to hospitals and teaching institutions. The institute is now housed in congested and inadequate quarters.

Principal speaker at the ceremony was Maj. Gen. George E. Armstrong, surgeon general of the Army. Talks also were given by Dr. Leonard A. Scheele, surgeon general of the Public Health Service; Dr. Joel T. Boone, representing the Veterans Administration, and representatives of the Navy and Air Force surgeons general.

Scheduled to be completed in two years, the Armed Forces Institute of Pathology building will cost $7,250,000 and provide 200,000 square feet of working space. Adequate quarters will be provided for the four main departments: American Registry of Pathology, medical museum, pathology laboratories and medical illustration service. The registry and the laboratories make their facilities available to non-governmental hospitals and teaching institutions, as well as to military and other federal agencies.

New Name for Marine Hospitals

Federal hospitals formerly known as United States Marine Hospitals henceforth will be called United States Public Health Service Hospitals, Dr. Leonard A. Scheele, surgeon general of the Public Health Service, has announced.

The hospitals acquired the name "Marine" because of legislation approved by President John Adams in 1798 creating a medical care program for merchant seamen. Since then, however, Congress has increased the number of groups entitled to treatment at the hospitals and the name is no longer suitable.

Twenty-one United States Marine Hospitals, in ports along the ocean and gulf coasts, the Great Lakes and the Mississippi River, were affected by the name change. Also affected were two tuberculosis hospitals and the leprosarium at Carville, La.

Katherine Lenroot Retires

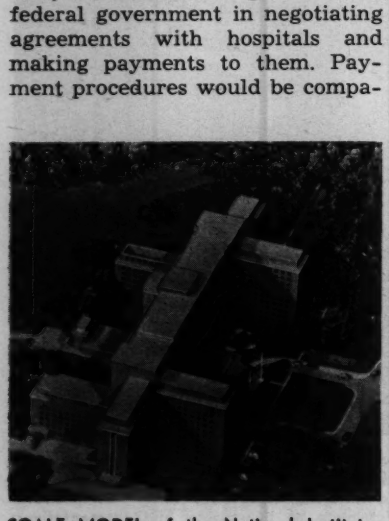
The resignation of Katherine F. Lenroot as chief of the Children's Bureau of the Federal Security Agency has been accepted by President Truman.

Miss Lenroot, who has served with the bureau for 37 years, has been chief for the last 17. She plans to retire but said she will continue to be interested in the affairs of children.

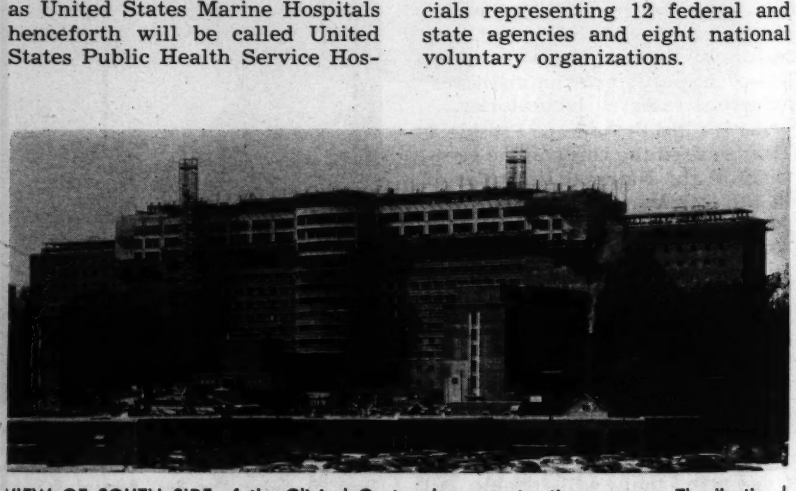
Dr. Martha Eliot, who recently resigned as assistant director-general of the World Health Organization in charge of advisory services, has been nominated as Miss Lenroot's successor. Dr. Eliot was formerly associate chief of the Children's Bureau.

Standards for Nursing Homes

Standards for nursing homes and other institutions that care for needy aged and handicapped persons were discussed at a recent meeting of health and welfare officials representing 12 federal and state agencies and eight national voluntary organizations.



SCALE MODEL of the National Institutes of Health Clinical Center, now being built.



VIEW OF SOUTH SIDE of the Clinical Center shows construction progress. The "national center for the advancement of national health" is scheduled for completion late next year.

The meeting was called by the director of the bureau of public assistance, Federal Security Agency, to develop policies for carrying out one of the new social security amendments.

Under the amendment, states must establish standards in order to get federal funds for public assistance payments to eligible persons in private and public nursing and convalescent homes and in hospitals. The amendment is not effective until July 1, 1953.

Mental Hospital Statistics

Eleven states with well-developed programs of mental hospital statistics will form the core of a new reporting area for the compilation of such data.

Officials from mental hospitals in Arkansas, California, Illinois, Louisiana, Michigan, Nebraska, New Jersey, New York, Ohio, Pennsylvania and Virginia attended a conference of mental hospital administrators and statisticians held recently under the sponsorship of the Mental Health Institute of the National Institutes of Health. The new reporting arrangement, agreed on at this conference, is expected to result in more uniform and adequate statistics on mental patients.

Dr. Murdock Resigns

Dr. John R. Murdock, assistant director of the Pan American Sanitary Bureau, regional office of the World Health Organization, has resigned after nearly 15 years of service.

Dr. Murdock, author of a number of scientific articles on public health, is returning to work with the Public Health Service as a medical director.

Cooperative Health Chief

Dr. Dale C. Cameron has been appointed chief of the Cooperative Health Services Branch of the Division of Industrial Hygiene, Public Health Service. He had been assistant director of the National Institute of Mental Health.

Dr. Cameron is a fellow of the American Psychiatric Association and a member of the American Medical Association, the Group for the Advancement of Psychiatry, and the Southern Psychiatric Association.

Scientific Director

Dr. Seymour S. Kety has been appointed scientific director for the joint research program of the Mental Health Institute and the new Neurological Diseases and Blindness Institute of the National Institutes of Health.

Dr. Kety formerly was professor of clinical physiology at the graduate school of medicine at the University of Pennsylvania.

Army Hospital Management

The office of the surgeon general of the Army recently conducted a two-week workshop at Fitzsimons Army Hospital, Denver, to evaluate the progress made in the last year in hospital management improvement.

In the last year all the Army's large named hospitals in the United States were reorganized according to a new structure outlined by the surgeon general. New procedures were implemented and local management improvement projects were initiated.

Grants for Research

A program of federal aid for expanding cancer research facilities throughout the country is nearing completion. Since the beginning of the program in 1947, the Public Health Service has awarded $16,303,000 to aid cancer research construction projects at non-federal institutions.

Public Health Service grants also will be given to investigate methods of inducing breathing in newborn infants who are threatened by asphyxiation because of faulty lung action. Director of the study will be Dr. Peter Gruenwald of Beth-El Hospital in Brooklyn.

Division of State Grants

Dr. Jack C. Haldeman has been appointed chief of the Division of State Grants, Public Health Service, succeeding Dr. Estella Ford Warner, who was assigned recently to a Point Four mission in Beirut, Lebanon.

Since 1948, Dr. Haldeman has been medical director of the Arctic Health Research Center in Anchorage, Alaska. In his new job, he will administer the Public Health Service multi-million dollar program of grants-in-aid to states for the development of public health services. Dr. Haldeman also will direct a program of technical and consultive services provided, on request, to state and territorial health authorities.

FIRST PERMIT for hospital construction (under new federal regulation requiring authorization to build) was signed in Washington on June 8. The permit was granted to the Mississippi State Hospital, Jackson. Charles G. Lavin, acting chief, Division of Civilian Health Requirements, Public Health Service, is shown above signing the permit. Looking on are (left to right) Leonard P. Goudy, secretary of the American Hospital Association's Council on Administrative Practice, editor of the purchasing department of HOSPITALS and a consultant to the surgeon general; W. D. Hilton, executive secretary, Board of Trustees of Mental Institutions, Jackson, Miss.; and Paul A. Caulk, executive officer for administration, Public Health Service, representing Surgeon General Leonard Scheele.

National Health Legislation

The return to Washington in mid-July of Sen. James E. Murray, chairman of Senate Labor and Public Welfare Committee, is expected to herald an upsurge of Congressional activity on national health legislation. Senator Murray had gone to Europe in late spring to attend meetings of the International Labor Organization, and few meetings of the committee, which has a number of health bills pending, took place during his absence.

One of Senator Murray's first acts upon his return to the capital was to send a telegram to state governors asking them to supply detailed information on numerical adequacy of physicians in their respective areas and to submit recommendations on how relocation on a voluntary basis might be effected to relieve "doctor-short" regions. It was explained that the information is desired for guidance in drafting new health legislation.

The Clark report: At a committee meeting scheduled for the latter part of July, the Senators were to take up the matter of legislative use of a report on national hospital and medical care insurance plans. The report is based on a special study conducted under the direction of Dr. Dean A. Clark, general director of Massachusetts General Hospital, Boston.

Although the Clark report makes no specific recommendations on enactment of new laws, the data presented on national coverage by voluntary and indemnity plans, together with conclusions on existing gaps, are certain to influence the type of health legislation to be considered in 1951 and 1952 by the present 82nd Congress.

One of the first direct results will be the introduction soon, of a bill sponsored by Sen. Hubert H. Humphrey (D., Minn.) on federal financial assistance to cooperative health plans. Public hearings were held on a similar bill filed last year by Senator Humphrey but it made no progress on Capitol Hill.

Payments for Indigent Care

A bill providing for increased payments to hospitals in Massachusetts for care of indigent patients was signed by Governor Dever and will become effective October 1.

Under the bill, the state will pay a maximum of $12 a day for the care of indigent patients, instead of $10. The increase will give hospitals an additional $640,000 annually, it is estimated.

Federal Aid in Disasters

The Senate Banking and Currency Committee is considering a question that vitally concerns the nation's hospitals. It deals with federal financial assistance to hospitals, schools, utilities, and other community facilities that are damaged or destroyed as result of enemy attack. Sen. J. Allen Frear Jr. (D., Del.) is sponsoring a bill (S. 1848) whose passage has been requested by the Bureau of the Budget on the ground that government must assume a degree of responsibility for rehabilitating institutions suffering atomic or any other kind of disaster at the hands of an enemy.

S. 1848 also provides for reimbursement out of government funds to hospitals rendering services to attack victims. "Such benefits and care," says the bill, "may be provided through payment of the cost thereof, either in advance or by way of reimbursement, to the person or public or private agency, institution or organization furnishing the benefits or, where this is not feasible, to the beneficiary."

Animals for Research Use

A bill denying public funds to humane societies refusing to turn over unclaimed animals to medical schools has been signed by the governor of Wisconsin, the National Society for Medical Research has announced.

Civil Defense Film

The Federal Civil Defense Administration has issued a motion picture entitled "Survival Under Atomic Attack." It is the first of a series of nine official FCDA films concerning preparation for an emergency.

The cost of the film is $17.50 for 16 mm. sound prints. Persons wishing information on how to obtain the film should write the Editorial Department of HOSPITALS, 18 E. Division Street, Chicago 10.

W. MALCOLM McCLEOD (left), superintendent of Elizabeth General Hospital and Dispensary and president of the New Jersey Hospital Association, presents a plaque on behalf of the association to A. W. Eckert, director of Perth Amboy (N. J.) General Hospital. The award commends the hospital for "illustrious service to humanity" in caring for the 196 injured from the South Amboy munitions blast in May 1950 and the 224 injured from the Feb. 6 train wreck at Woodbridge (See HOSPITALS, Sept. 1950, p. 60, and April 1951, p. 41). The presentation was made at the annual banquet of the New Jersey Hospital Association during the Middle Atlantic Hospital Assembly convention at Atlantic City in May.

Report on Veterans Administration

Slightly over five months after launching its investigation of hospital and medical care policies of The Veterans Administration, a special subcommittee of the Senate has issued a formal report that may prove to be as controversial as the incident that brought about the investigation itself. This was the discharge, last January, of Dr. Paul B. Magnuson as chief medical director.

Certain recommendations of the subcommittee, whose chairman was Sen. Hubert H. Humphrey (D., Minn.), call for Congressional legislation tightening medical control over the Veterans Administration's vast hospital system. While these proposed reforms are not controversial themselves, they raise a question whether Congress may prefer to overhaul the entire federal medical-hospital structure instead of making piecemeal changes within the administration.

In mid-July, the Humphrey subcommittee released a 471-page printed transcript of the hearings which, together with the findings and recommendations, comprise the most thorough examination ever undergone by the Department of Medicine and Surgery in the Veterans Administration. They disclose the opinions of such civilian experts as Dr. Howard A. Rusk, Dr. Paul R. Hawley and Dr. Hugh Wood, as well as officials of the armed forces, Public Health Service and the Veterans Administration. Placed under particularly close scrutiny was the Veterans Administration's relationship with teaching institutions.

Recommended statutory changes are:

1. Amend the law "so as to leave no doubt whatsoever that the Congress intends the chief medical director . . . to be the principal medical authority of the agency with primary authority to control, manage and operate its medical and hospital program."

2. Make the office of chief medical director (now filled by Dr. Joel T. Boone, successor to Dr. Magnuson) one that is filled by presidential appointment, in same manner as the surgeons general of Army, Navy, Air Force and Public Health Service.

3. Reorganize and strengthen the special medical advisory group, now serving Administrator Carl R. Gray Jr., so that its members shall be appointed by the President to represent public, veterans and medical interests.

Other recommendations, which can be effected by administrative action, are as follows:

1. Delegation by Administrator Gray to the chief medical director of "such primary authority as may be necessary to assure his effective control over all policy affecting the care and treatment of patients and over the management and operation of the hospital system."

2. Managers of Veterans Administration hospitals would not be appointed without prior approval by the chief medical director.

3. Placement of all "special services" personnel, such as recreation, educational and welfare, on duty at veterans hospitals under direct control and supervision of the institution's manager and within scope of policies laid down by the Department of Medicine and Surgery.

4. Revision of budgetary control procedures for the purpose of simplifying fiscal duties of hospital managers.

5. Initiation of personnel ceiling procedures by the administrator that will give the chief medical director greater flexibility in allocation of personnel in hospitals.

"If (these recommendations) are adopted and if General Gray thus vests in his chief medical director the sort of authority he told us he was prepared to grant, we are sure that the deans of our medical schools will be able to evince the same confidence in their official relationships with Admiral Boone as Dr. Magnuson has unequivocally told us Admiral Boone deserves as an individual," the report concludes. "The re-creation of such a tripartite relationship on this basis will mean the re-establishing of those same bonds which gave this country a veterans medical care program second to none."

Veterans Appoint Consultants

The Veterans Administration has announced the appointment of Dr. Charles L. Brown, professor of medicine and head of the department of medicine at Temple University and Hahnemann Medical School, and Dr. Charles E. Kossmann, associate professor of medicine at New York University, to the Veterans Administration board of chief consultants.

Dr. Brown was appointed chief consultant in internal medicine and Dr. Kossmann, cardiology.

Music Therapy for Veterans

Resulting from a three-day seminar in the use of music with hospitalized patients, the Veterans Administration now has a standardized musical activities program for all its hospitals, according to F. R. Kerr, assistant administrator for special services of the Veterans Administration.

The seminar, held at Downey (Ill.) Veterans Administration Hospital, featured discussions by physicians and others who have worked with music in hospitals, as well as demonstrations showing how music can be used in treatment programs. Among the demonstrations were concerts by an all-patient orchestra, band and glee club at Downey Hospital, and a portrayal of the part music plays in the treatment of lobotomy patients.

Hospital Volunteers

A committee composed of the directors of volunteer workers in 15 hospitals serving metropolitan Boston has been functioning for several years and would like to correspond with similar organizations. Harriet F. Parker, secretary to the Boston Committee of Directors of Hospital Volunteers and director of the Boston Volunteer Service Bureau, requests this correspondence from individuals or committees who are concerned with volunteer service in hospitals or persons interested in forming a committee similar to the Boston group.

Miss Parker's address is United Community Services of Metropolitan Boston, Mason Memorial Building, 14 Somerset Street, Boston 8.

Actions of the Board of Trustees

Important actions of the Association's Board of Trustees at its June meeting in Washington, D. C., include the following:

Hospital—specialist relations: Future board problems of hospital relationships with medical specialists will be discussed on a national level as a result of an agreement between the American Hospital Association and the American Medical Association. At its June meeting in Washington, the Board of Trustees of the American Hospital Association endorsed the idea of a joint committee, representing the trustees of both associations, to discuss such problems around the conference table.

The American Medical Association agreed to the idea earlier, after the idea had been proposed by the House of Delegates of the American Hospital Association last September.

The joint committee is expected to consist of five members of each of the two boards of trustees. President Charles F. Wilinsky, M.D., was authorized to appoint the representatives of the American Hospital Association. These representatives are to serve until the St. Louis convention next month, with the understanding that the composition of the committee may be changed at that time in accord with any changes in board membership which may occur then.

Regional meetings of House: In order to keep the House of Delegates fully informed of the complex issues that will be presented at next month's convention in St. Louis, the Board of Trustees has authorized Executive Director George Bugbee to set up regional conferences of the House, to be attended also by members of the Board of Trustees and the Coordinating Committee.

Subjects to be discussed at these regional conferences include the hospital accreditation program; the disposition of the $100,000 reserved for accreditation; the proposed revision of the Association's by-laws, and negotiations with the American Medical Association on problems of hospital-physician relationships.

Field representative: A fulltime field representative was authorized for the Association's headquarters staff at the June 23 meeting of the Board of Trustees. At its February meeting, the board authorized a budget change to cover travel expenses and the salary of such a traveling representative.

The representative will be concerned with membership promotion and other activities of interest to the Association.

International congress: Several members of the American Hospital Association were present at last month's congress of the International Hospital Federation in Brussels, Belgium.

The Board of Trustees designated Dr. Donald C. Smelzer, Ritz E. Heerman, Dr. Joseph Turner, the Rt. Rev. Msgr. John J. Healy, the Rev. Donald A. McGowan, James Russell Clark, and President-elect Anthony J. J. Rourke, M.D., as the Association's representatives.

Intern matching plan: The American Hospital Association, through its Board of Trustees, has approved, subject to a favorable mail vote of a majority of the hospitals approved for internships, a one-year trial of the mechanical matching system for intern appointment.

This system, which was conducted on a "dry-run" practice basis last year, has been recommended for adoption by the National Interassociation Committee on Internships, representing the American Protestant Hospital Association, the American Medical Association and the Association of American Medical Colleges. (See HOSPITALS for May, page 68.)

The interassociation committee recently reported that last year's test was generally successful.

Accreditation Program

A joint hospital accreditation program, to begin about April 1, 1952, was assured last month after a meeting of representatives of the four organizations concerned, pending only the approval of the American Hospital Association's House of Delegates.

Meeting in Chicago, officials of the American Hospital Association, the American Medical Association, the American College of Surgeons and the American College of Physicians agreed to go ahead with the program as proposed—that is, governed by an 18-member Joint Commission on Hospital Accreditation financed jointly by the four organizations.

When the American Medical Association met in Atlantic City in June, its trustees were authorized to enter the joint program but were instructed to attempt to change the proportion of representation of the medical and hospital associations on the commission. This proposal met with no success at last month's meeting. The American Medical Association representatives then joined the others in approving the program as proposed.

Both the American College of Surgeons and the American College of Physicians formally approved the joint program earlier. The House of Delegates of the American Hospital Association will vote on the proposal at the Association's St. Louis convention next month.

If the Association's House of Delegates approves the plan, the chief executive officers of the four organizations then will incorporate the joint commission. It is expected that the trustees and regents of each organization will meet by early December to select their representatives to the joint commission.

The sponsoring groups hope to have an organizational meeting of the commission and to appoint its chief administrative officer by January 1. The commission then will establish procedures, rules and regulations governing accreditation and will be ready to establish the program by April 1 according to present plans.

Representation on the Joint Commission on Hospital Accreditation, according to present plans, will be as follows:

American Hospital Association—six members.

American Medical Association—six members.

American College of Surgeons—three members.

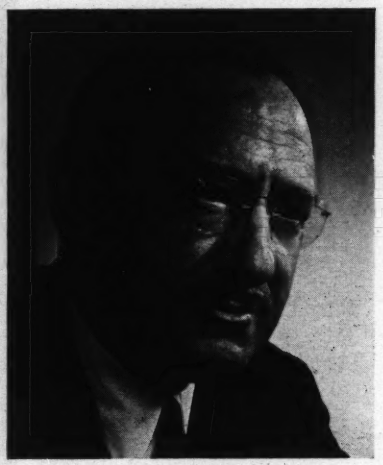
American College of Physicians—three members.

Earmarked money: Meanwhile, the Board of Trustees of the American Hospital Association, meeting in Washington, reported that the

$100,000 set aside last September for hospital accreditation is being held intact. A report of the financing and organization of the proposed accreditation program will be made to the House of Delegates at the St. Louis convention.

Conference Program

Frank L. Weil, president of the National Social Welfare Assembly, New York City, is the featured speaker at the closing luncheon on September 20 of the fourth annual conference of the Committee on Women's Hospital Auxiliaries. Mr. Weil, of the law firm of Weil, Gotshal and Manges, is also a member of the national executive



MR. WEIL

board of the Boy Scouts of America. In October 1948 he was appointed by President Truman as chairman of the President's Committee on Religion and Welfare in the Armed Forces.

The conference of women's hospital auxiliaries officially begins on Tuesday, September 18. A special meeting for state advisory counselors is planned for September 17.

In addition to work sessions and group conferences, the auxiliaries conference will have general sessions on civil defense and current hospital needs. Speaking at the latter program will be Albert V. Whitehall, assistant director of the American Hospital Association, Washington, D. C.; Donald M. Rosenberger, director of Maine General Hospital, Portland, and Donald W. Cordes, administrator of Iowa Methodist Hospital, Des Moines.

Auxiliary hotel headquarters will be at the Statler. Meetings will be at both the hotel and Kiel Municipal Auditorium.

· · PREPAID CARE · ·

Public Relations Winners

Winner of the grand award in the sixth annual Blue Cross and Blue Shield public relations contest was the Associated Hospital Service of Philadelphia.

The grand award is given to the plan that has the best over-all program of the year. It is the third time Philadelphia has won in this class. Awards were made at the national Blue Cross-Blue Shield Enrollment and Public Relations Conference July 11-13 in Chicago.

In Class I (for plans with more than 500,000 members), the winner was Associated Hospital Service and United Medical Service of New York City for an enrollment campaign in which the local doctors participated actively. Colorado Hospital Service and Colorado Medical Service won in Class II (200,000 to 500,000 members) for a non-group campaign in Denver in which every local agency and organization took part.

The Class III (100,000 to 200,000 members) winner was Associated Hospital Service of Arizona and Arizona Blue Shield Medical Service for an initial non-group campaign that was well planned and executed. Class IV (under 100,000 members) honors went to Hospital Service, Inc., the New Mexico Blue Cross plan, for a community relations program carried out under difficult circumstances.

Judges of the contest were John F. Ryan, manager of the press department, National Broadcasting Company; C. G. Wilson, information supervisor, Bell Telephone Company, and Frank Hicks, executive editor, *Hospital Management*.

The winning entries will be available for study.

Canadian Medical Plan

The Canadian Medical Association has announced plans for a national medical insurance program in which the government would pay premiums for those unable to do so.

The program, Trans - Canada Medical Services, is expected to cost $36 a year for a single person and $72 for a family of three. Parliament must adopt a bill, however, for formal incorporation of the organization.

1950 Financial Report

A total of $407,690,520 was paid to hospitals by the 90 Blue Cross plans for services rendered members in 1950. Payments for members care in 1950 represented the largest percentage of income that has been paid during any previous 12-month period and exceeded by almost $80,000,000 the amount paid in 1949.

Total earned subscription income for all Blue Cross plans in 1950 was $461,991,538 and 88.25 per cent of that amount went di-

REPRESENTATIVES of winning entries in the sixth annual Blue Cross-Blue Shield public relations contest receive trophies for their plans from Lawrence C. Wells, assistant director, Blue Cross Commission (third, left). They are (from left): C. Robin Jacobsen, director, Hospital Service, Inc., Albuquerque, N. M.; Alfred L. Golden, public relations director, Associated Hospital Service and United Medical Service, New York City; G. Donald Fairbairn, public relations director, Associated Hospital Service of Philadelphia, winner of the grand award trophy; Lee Robbins, public relations director, Colorado Hospital Service and Colorado Medical Service, Denver, and L. Donald Lau, executive director, Associated Hospital Service of Arizona and Arizona Blue Shield Medical Service, Phoenix.

rectly to hospitals for services to members.

Combined operating expenses for all plans was $39,923,417, or 8.42 per cent of total earned subscription income, the lowest in Blue Cross history.

Public Relations Assistant

Gilbert W. Longstreet has been appointed assistant manager, Public Relations Division of the Blue Cross Commission.

He joined the commission staff in 1945 as a member of the public relations group and has been concerned with editorial research, preparation of articles and reports, and layout, development and production of promotional material. Before joining the commission staff, he did enrollment and public relations work with the Kansas Blue Cross Plan.

Blue Shield Enrollment

During the first quarter of 1951, the 72 Blue Shield plans acquired 816,064 new members and the 11 nonmember plans acquired 108,270 new members, a total growth of 924,334.

The increase brought the total membership in the 72 plans to 17,445,660. It is now 2,594,729 in the nonmember plans. Four Blue Shield plans increased their membership by more than 50,000 during the first quarter. New York City led all plans with an increase of 124,037 members.

Financial Report

The Blue Cross Commission recently released a report on the financial status of 91 Blue Cross plans at the end of the first three months of 1951.

More than $120,000,000 was spent for hospitalized members during the period. This represents 92.99 per cent of the total earned income. Operating expenses were at a low level of 8.53 per cent.

New Payment Method

A new payment procedure, approved by the Massachusetts Hospital Association's Council on Blue Cross Affairs, now gives participating hospitals advance monthly payments.

The first payment will equal the average monthly payment the hospitals received from Blue Cross during the first six months of 1951, and the succeeding monthly payments will be in the amount of the previous month's voucher.

Limitations on Service

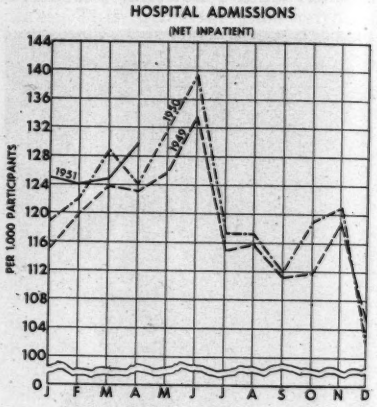
Ten of the 90 approved Blue Cross plans place no dollar limitation on any of the services offered to their members, the Blue Cross Commission has reported.

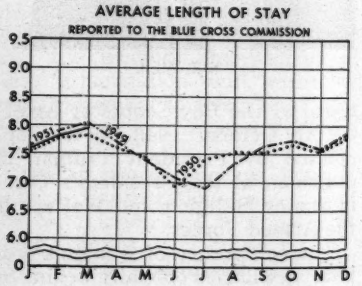
The other 80 plans limit one or more of their certificate benefits in terms of maximum dollar allowances.

Fifteen plans limit benefits by percentage of service covered. Ten of these limit only one service. Eight plans require cooperative or co-insurance payment by their subscribers and/or dependents during hospitalization.

Only seven of the 90 approved plans have no limitations.

LAWRENCE C. WELLS, assistant director of the Blue Cross Commission, talks over the counter of an old time variety store to sell his seven basic rules for success to public relations men at the Blue Cross-Blue Shield Public Relations and Enrollment Conference held recently in Chicago. He illustrated points in his talk "It Was Good Enough for Grandpa; Is It Good Enough for Us?" with a unique application of old fashioned proverbs.





ADMISSION-STAY

The April admission rate rose to 130 per 1,000 participants, breaking the almost level rates of the first three months of 1951. The April 1950 rate was 124 admissions per 1,000 participants.

Stays of hospitalized Blue Cross members increased from 7.83 days in February to 7.93 days in March. The average stay during March 1950 was 7.87.

Blue Cross plans provided an average of 977 days of care per 1,000 participants during March 1951. This is an increase of approximately 2 per cent over February, the same increase as a year ago. The plans provided seven days of care less during March 1951 than during March 1950.

Top-efficiency hospitals like Boston's Beth Israel combine luxury and economy with

Goodall Fabrics

Aerial view of Beth Israel Hospital, nurses' home, and extensive grounds in Brookline, Mass.

This typical semi-private room in Beth Israel shows the restful influence of Goodall Fabrics. Cheerful "Gingham Apples" draperies are emphasized by the simplicity of "Gothic" cubicles and "Chateau" bedspreads. Chairs are richly upholstered in sturdy "Gros Point."

The living room of Beth Israel's nurses' dormitory invites relaxation with home-like Goodall Fabrics. Chairs are covered with pleasant-textured "Mandarin," "Commando," "Angora Stripe," "Beekman"... sofas with "Claremont," "Beekman," and "Angora Stripe." "Foliate" draperies are smartly color-coordinated.

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Goodall Upholstery
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Hospital Council Officers

Arthur Feigenbaum, superintendent of Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn, was elected president of the Hospital Council of Brooklyn, Long Island and Staten Island at a recent meeting at Mercy Hospital, Rockville Centre, N. Y.

The Rev. Clarence A. Morrill, Methodist Hospital, Brooklyn, was elected vice president, and Sister Ursula Marie, administrator of Mary Immaculate Hospital, Jamaica, was elected secretary.

The new executive committee is composed of Mr. Feigenbaum; the Rev. Morrill; Sister Ursula Marie; H. F. Rudiger Jr., director of Southside Hospital, Bay Shore; Dr. I. Magelaner, medical superintendent of Kings County Hospital, Brooklyn; Sister Mary Anna, superintendent of Mercy Hospital, Rockville Centre, and Louis Schenkweiler, superintendent of Wyckoff Heights Hospital, Brooklyn.

Methodist Hospitals

The National Association of Methodist Hospitals and Homes is planning its 1952 convention for February 20-21 at Cleveland, Ohio. Convention headquarters will be the Statler Hotel.

Speakers scheduled to speak so far are Prof. B. G. Childs of Duke University; Bishop Hazen G. Werner, and Bishop Donald H. Tippett.

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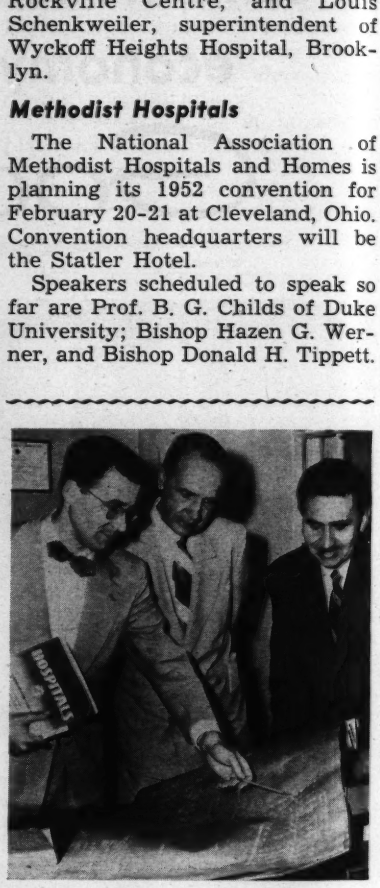

Rochester Council Visitors

Recent visitors at the office of the Council of Rochester Regional Hospitals were Dr. Marcello G. Leite (center), San Paulo, Brazil, and Dr. Raul Palma (right), Valparaiso, Chile. Jacques Cousin (left), assistant director of the council, points out features of plans for a new hospital building being constructed with council assistance.

The doctors are both administrators of large hospitals and are in this country on Kellogg Foundation fellowships to study hospital administration. They are just two of a group of visitors from other countries who have visited the council offices this year to study the organization and operation of a regional hospital program.

Public Health Association

San Francisco has been selected as the site of the 79th annual meeting of the American Public Health Association, October 29 to November 2, according to Dr. Reginald M. Atwater, executive secretary of the association. Thirty-eight related organizations and the western branch of the American Public Health Association will be meeting there simultaneously.

Modern public health practice in all its aspects and its relationship to national security and civil defense will be discussed by more than 400 authorities. The 13 sections in the association will sponsor symposiums on such subjects as industrial hygiene, food and nutrition, and maternal and child health.

Greater New York

Fred Heffinger, superintendent of the Manhattan Eye, Ear and Throat Hospital, has been elected president of the Greater New York Hospital Association.

Other officers are: President-elect, Dr. Henry N. Pratt, director of New York Hospital; vice president, Dr. A. P. Merrill, superintendent of St. Barnabas Hospital for Chronic Diseases; treasurer, Louis Miller, superintendent of Jewish Memorial Hospital; secretary, Fred Fish, director of Lutheran Hospital of Brooklyn; executive director, John V. Connorton, Ph.D.; counsel, Emanuel Hayt.

Idaho

More than 75 delegates and representatives of hospital and allied associations in Idaho attended the spring meeting of the Idaho Hospital Association in Boise May 21-22.

The principal topics of discussion were prepaid hospital insurance and hospital public relations. Leo O'Connel, commissioner of insurance for the state of Idaho, spoke on "The State and Prepaid Hospital Plans and Health and Accident Insurance." "The Formation of an Idaho Hospital Association Insurance Acceptance Council" was discussed by Sister Jeanne, Sacred Heart Hospital, Idaho Falls.

The association was formally incorporated as a nonprofit corporation under the Idaho laws.

Diagnostic Health Clinics

The Hospital Council of Greater New York has announced that it cannot endorse the establishment of diagnostic clinics at health centers operated by the Department of Health that are isolated from hospitals.

The council pointed out that such clinics duplicate facilities, personnel and equipment already available at general hospitals; render incomplete service; and remove their personnel from the center of medicinal activity.

New Mental Health Group

Three national groups have merged to form the National Association for Mental Health in an endeavor to bring the central truths of mental health to the attention of every person in the United States, according to the president of the new organization, Oren Root, New York City attorney.

In addition to publicizing the truths of mental health, the association will work to make psychiatric services more available and promote research programs.

Dr. George S. Stevenson, past president of the American Psychiatric Association, is medical director of the new group. The three groups which joined together in the association were the National Committee for Mental Hygiene, National Mental Health Foundation and Psychiatric Foundation.

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Hospital Beds Needed

The Joint Hospital Survey and Planning Commission has reported New York City needs 11,310 more general hospital beds to meet peak needs.

Many of the needs are as replacements for facilities that are obsolete and not fire resistant. The figures do not include chronic, tuberculosis or psychiatric needs. In addition the need has been stressed for state financial assistance and leadership in strengthening the working relationships between large and small hospitals and medical schools.

University of Chicago

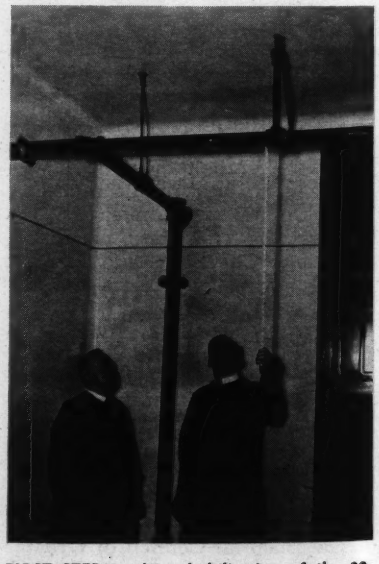
Ground was broken in June for two new specialized hospitals to be added to the University of Chicago Clinics, making a total of 709 hospital beds in the medical center.

Seventy-five beds will be added by the construction of the Charles Gilman Smith Hospital for research and treatment of contagious and heart diseases. The other hospital, with 92 beds, will be the west wing of the clinics group and will be for research in orthopedics and in chronic diseases, including tuberculosis, allergy, arthritis and metabolic disorders.

Construction and equipment costs for the two hospitals is estimated to be $4,500,000. In addition to the Charles Gilman Smith memorial fund of $574,000, the new buildings are being financed in part by grants of $485,000 from the Federal Security Agency and $690,000 from Hill-Burton funds.

Fund-Raising Campaigns

The $450,000 building fund campaign of Franklin (Pa.) Hospital has reached a total of $529,555,



FIRST STEP in the rehabilitation of the 82-year-old Alexian Brothers Hospital in St. Louis was the installation of an automatic sprinkling system. Two Alexian brothers are shown above inspecting progress of the work.

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and additional subscriptions are expected to increase the amount to $560,000.

The money will make possible 32 additional beds to make a total of 117; increased laboratory and clinical facilities; a new complete kitchen, and fire resistant treatment of the original hospital building.

Mercy Hospital in Muskegon, Mich., ended a recent building fund campaign with a total of $625,995, which was $175,995 more than the goal. The hospital's medical staff subscribed $122,560, or 27 per cent of the goal.

The hospital plans to build a five floor addition to remedy the shortage of hospital beds in the area.

Waupun Hospital Dedication

Waupun (Wis.) Memorial Hospital was dedicated July 5 at a pontifical Mass, celebrated at the hospital by Archbishop Moses E. Kiley. The 90-bed institution, built at a cost of $2,500,000, is operated by the Franciscan Sisters.

Expansion Program

Montgomery Hospital in Norristown, Pa., is planning a $1,750,000 expansion program which will enlarge the hospital capacity to 285 beds and provide a new school of nursing building.

A new wing to the hospital will be built at a cost of $1,000,000. The nursing building will cost $750,000.

Plans for the additions were approved after a study revealed existing facilities were not adequate to meet steadily increasing demands.

Butler Hospital Addition

Ground was broken late in June for a new six-floor wing to Butler (Pa.) County Memorial Hospital and for a three-floor addition to Sarver Hall, the nurses' home at the hospital.

The construction, to cost $3,500,000, will take about 18 months.

Dr. Glidden L. Brooks, professor of hospital administration at the University of Pittsburgh, was a speaker at the ceremony.

Hospital for Drug Addicts

The Riverside Hospital on North Brother Island in the East River, New York City, is to be put into use soon as a hospital for young narcotics addicts.

Dr. Marcus D. Kogel, commissioner of hospitals in New York City, announced that the hospital would be prepared for use at a cost of $200,000. A staff of 200 on the island would include psychiatrists, psychologists, vocational guidance and social workers.

Master Plan for Hospitals

The Hospital Council of Greater New York has released its "Master Plan for Hospitals and Related Facilities for Nassau and Suffolk Counties (Long Island)."

The major finding and recommendation of the plan provides for a substantial increase in beds in the two counties, particularly in Nassau. Already under construction are 275 general care beds—235 in Nassau and 40 in Suffolk. There are 995 general beds still needed—880 in Nassau and 115 in Suffolk.

The plan was prepared at the request of the Long Island Regional Hospital Planning Council.

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FLOOR-SAN has been improved so that no matter how hard the water you use may be, there is no soap scum or hard water curd formed. That means the "ring around the bath tub" and the film that dulls your floor or walls is banished. Floor-San now contains complete water hardness controls. There is no undesirable reaction with hard water. None of the cleaning power of Floor-San is lost. It's safe on any surface that will stand water . . . and it's a safe bet that Floor-San will save many cleaning dollars. Try it.

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Student Nurse Enrollment

Students enrolled in state-approved schools of nursing numbered 102,509 on Jan. 1, 1951. This is the largest enrollment ever reported with the exception of the war years, 1944-47.

With the increase in students, however, has been an accompanying decrease in the number of schools. In the last 20 years, the number of students has increased 24 per cent, from 82,989 in 1931 to 102,509 in January 1951. The number of schools has decreased 35 per cent, from 1,802 schools in 1931 to 1,170 at the present time. Thirty-six of the schools now operating are preparing to close.

Of the 47 schools in which there are less than 20 students enrolled, 23 are planning to close. Many of these small schools do not have enrollments of even 20, and there is a question of how such schools can afford to maintain the classes. It has been suggested that central schools might solve the problem.

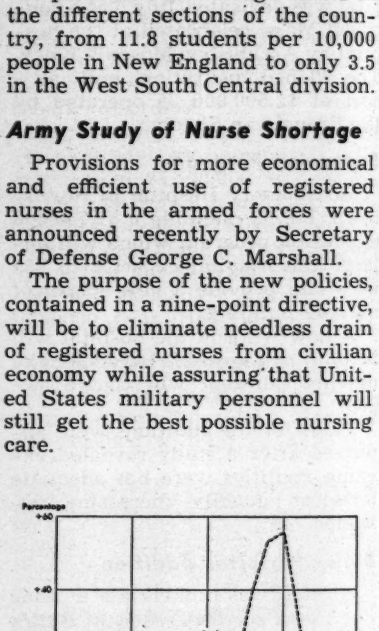
There are 59 schools having an enrollment of 200 or more, and one school has 400 students.

Of the total enrollment, 101,873 are residents of the United States. This means there is an average of 6.8 nursing students for each 10,000 persons. The average varies in the different sections of the country, from 11.8 students per 10,000 people in New England to only 3.5 in the West South Central division.

Army Study of Nurse Shortage

Provisions for more economical and efficient use of registered nurses in the armed forces were announced recently by Secretary of Defense George C. Marshall.

The purpose of the new policies, contained in a nine-point directive, will be to eliminate needless drain of registered nurses from civilian economy while assuring that United States military personnel will still get the best possible nursing care.



THE CHART ABOVE shows the per cent of change in number of state-approved schools of nursing and students enrolled each year since 1931. The decrease in both between 1932 and 1935 may have been caused by the depression. The sharp increase in enrollment between 1941 and 1946 was due to World War II and creation of Cadet Nurse Corps.

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Florence Nightingale Award

The Florence Nightingale Medal, one of the highest honors of the international committee of the Red Cross, was awarded to Col. Florence A. Blanchfield, former superintendent of the Army Nurse Corps,

MISS NELSON

COLONEL BLANCHFIELD

and Sophie Nelson, chairman of the National Nursing Council during World War II.

The awards were presented at the annual convention of the American Red Cross in New York by Florence Johnson, dean of nursing in the New York chapter of the American Red Cross.

In addition to her service in the Army Nurse Corps, Col. Blanchfield has been secretary of the Philippine Islands committee on Red Cross nursing service and a member of the District of Columbia committee on Red Cross nursing service. She also was a member of the national committee on Red Cross nursing service.

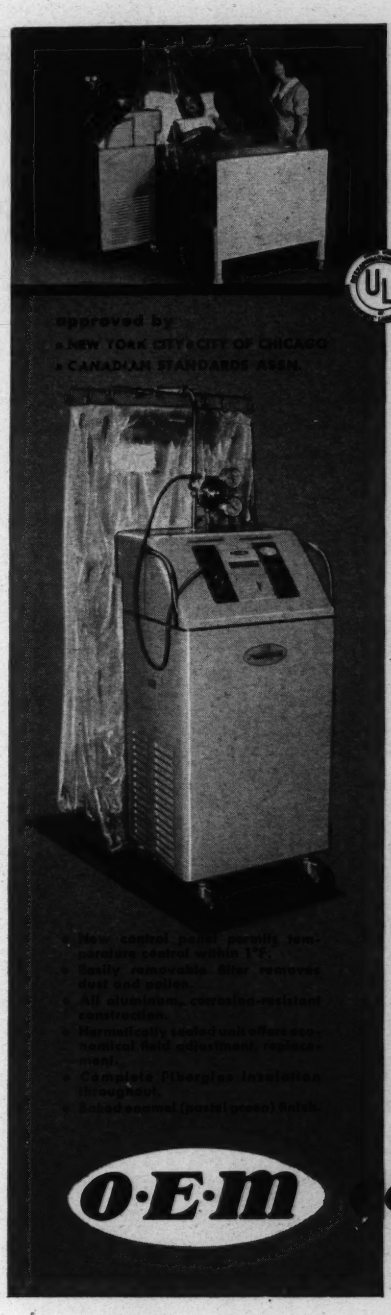
After being enrolled as a Red Cross nurse in 1917, Miss Nelson worked in France, Montenegro, Albania and Greece. Since 1926 she has been director of the nursing services of a Boston life insurance company and is now secretary of that organization.

Cuban Stamp Honors Nurse

A commemorative stamp honoring Clara Louise Maass, historic United States Army nurse, is to be issued by the Republic of Cuba on August 24. A presidential decree authorized the emission of 3,000,000 copies of the stamp, value of 2 centavos.

Nurse Maass, a graduate of Lutheran Memorial Hospital, East Orange, N. J., died in Cuba on Aug. 24, 1901, as the result of her voluntary submission to the bite of a Stegomyia mosquito, then suspected as a carrier of yellow fever virus. The only American to perish in the course of the experiment by the United States Army, her death gave final proof of one cause of the disease.

A similar stamp, honoring Nurse Maass as a symbol of "The American Nurse in Peace and War," has been requested of the United States Post Office Department by the nurses of the United States, headed by the American Nurses Association.



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The O.E.M. Mechanaire is also equipped with the *full-bed* O.E.M. Cleerlite Transparent Permanent Canopy (thickness, 5 mil). It is waterproof, will not pit or stipple in oxygen, is resistant to air, alcohol, acids—does not deteriorate or become brittle.

The O.E.M. Mechanaire is the lightest oxygen tent available today, weighing only 175 pounds. It handles easily with practically no effort.

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Washington Residents

Washington University has announced residency appointments for its 1951 class of hospital administration students.

BELL, RODERIC, to Boone Powell, administrator, Baylor University Hospital, Dallas, Texas.

BIRTHELMER, WILBUR, to Gerhard Hartman, superintendent, State University of Iowa Hospital, Iowa City.

CAMPBELL, EDWIN C., Army.

CANEDY, JAMES, to Hal Perrin, administrator, Bishop Clarkson Memorial Hospital, Omaha.

DIAZ-BENABE, AUGUSTIN, to Dr. J. Serra Chavarry, manager, San Patricio's Hospital, San Juan, P. R.

EDWARDS, LT. EUGENE G., MSC., to commanding general, Fitzsimons Army Hospital, Denver.

FORD, DORA BELLE, to Harry J. Mohler, president, Little Rock (Ark.) Hospital.

GOFF, CHARLES M., to Dr. Frank Sutton, director, Miami Valley Hospital, Dayton, Ohio.

HAGEDORN, DOROTHY, to Dr. Curtis Lohr, superintendent, St. Louis County Hospital, Clayton, Mo.

LEA, ROLAND, to Dr. Curtis Lohr, superintendent, St. Louis County Hospital, Clayton, Mo.

LOHR, LT. CHARLES G., to commanding officer, Medical Field Service School, Brooke General Hospital, Fort Sam Houston, Texas.

MARSHALL, FREDERICK, to Dr. Albert Kerlikowske, director, University Hospital, Ann Arbor, Mich.

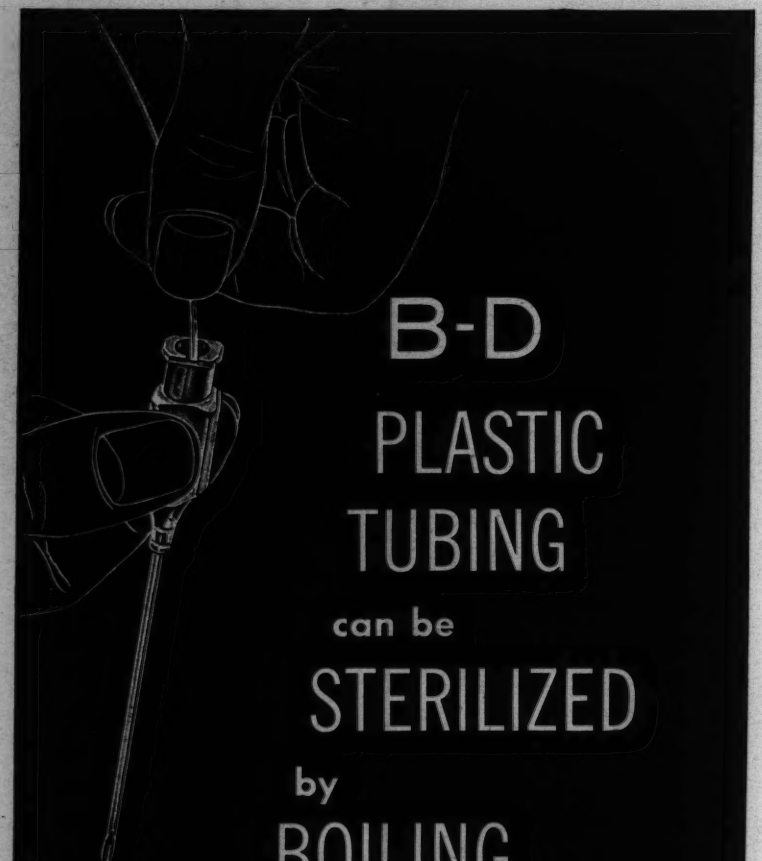
SCHERMIN, CAPT. FRANK J., to Lt. Col. L. M. Keffer, executive officer, Station Hospital, Scott Air Force Base, Ill.

SIMONDS, WARREN W., to Dr. Frank R. Bradley, director, Barnes Hospital, St. Louis.

STAFFORD, GEORGE T. JR., to Robert Neff, administrator, Methodist Hospital, Indianapolis.

THOMPSON, LEONARD K., to Sample B. Forbus, director, Watts Hospital, Durham, N. C.

WORTLEY, NEIL C., to Horace Burgin, administrator, Burge Hospital, Springfield, Mo.



Seminar for Administrators

The Rochester (N. Y.) Regional Hospital Council has awarded certificates to 11 hospital administrators in the Rochester region who have successfully completed a seminar in hospital administration.

Those completing the course are: Eleanor S. Confer, superintendent of Shepard Relief Hospital, Montour Falls; Charles D. Corwin Jr., treasurer and business manager of Clifton Springs Sanitarium and Clinic; Estella Douglas, superintendent of Medina Memorial Hospital; Helen Dumack, administrator of Bethesda Hospital, Hornell; William D. Entley, superintendent of Arnot Ogden Memorial Hospital, Elmira; May H. Epke, administrator of Lakeside Memorial Hospital, Brockport; Clifford A. Holbrook, secretary of Iola Sanatorium, Rochester; Stanley W. Martin, administrative resident, St. Mary's Hospital, Rochester; Sister Mary Albert, administrative resident, St. Mary's Hospital, Rochester; Sister Miriam Joseph, St. James Mercy Hospital, Hornell, and Sister Rose Clare, St. Joseph's Hospital, Elmira.

Minneapolis Hospital Strike

Strikers went back to their jobs at 10 private hospitals in Minneapolis after a walkout in mid-July that seriously handicapped nine of the institutions and threatened to close the other.

Despite a state law forbidding strikes against charitable institutions, nonprofessional workers from the laundry, housekeeping, maintenance and dietary departments walked out and the union began picketing the hospitals, stopping deliveries of food and supplies. Police were called in to maintain order after violence was reported.

After the court issued a temporary injunction to the union to call off its pickets, the workers returned to work. A court order required hospitals to reinstate the strikers. Some of the hospitals had refused to do so because, they said, the workers had left before the strike was officially begun July 5. After an appeal by the hospitals, for a reconsideration of the order, the court took the matter under advisement on July 19.

The dispute arose from a union demand that hospitals accept an arbitration board's recommendation for a union shop with a work week of not more than six consecutive days, with two consecutive days off and a 15-cent-an-hour pay increase, retroactive to March 1. The hospitals granted a five-cent hourly increase in May. They refused to arbitrate except on wages and hours.

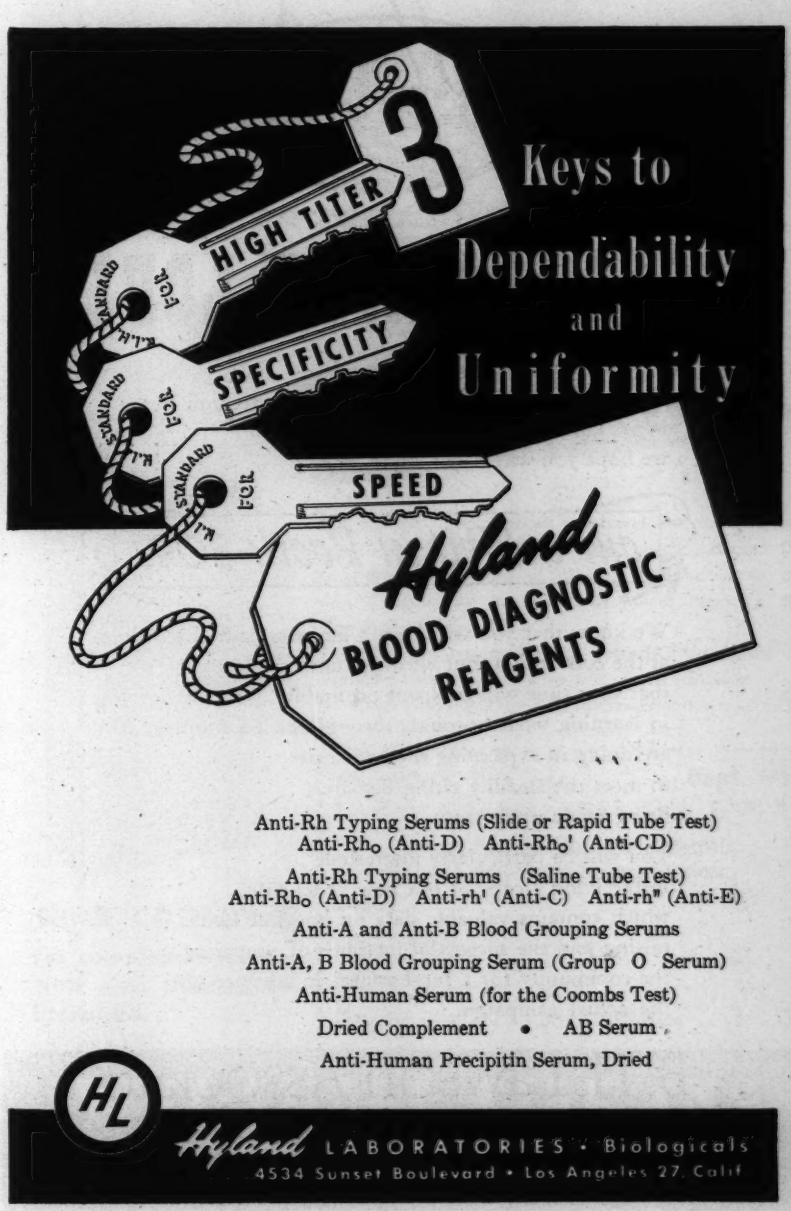
After the strike, a negotiating committee of five hospital trustees and five union representatives were attempting to work out a new contract. No hospital administrators and no representatives of the striking union, Public Service Employees Union, were on the committee.

The hospitals affected by the strike were Abbott, Asbury, Fairview, Swedish, Parkview, St. Barnabas, St. Mary's, Deaconess, Eitel, and Northwestern.

Quota Basis for Interns

Because of an increasing demand by hospitals for interns in the last 10 years, the number of internships offered by approved hospitals now exceeds the number of available applicants by at least 3,000. To prevent unfair competition for interns, the Council on Medical Education and Hospitals of the American Medical Association has announced the establishment of quotas for the appointment of interns, to become effective July 1, 1952.

The first list of hospitals approved will appear in the 1951 Internship and Residency Number of the *Journal* of the American Medical Association. In hospitals approved for intern training only, the number of internships offered for July 1, 1952, to June 30, 1953, will be limited to 80 per cent of the number offered in 1950 as listed in the 1950 Internship and Resi-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Anti-A, B Blood Grouping Serum (Group O Serum)
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dency Number or to the total number offered in 1940, whichever is the larger. This dual basis has been adopted to avoid penalizing hospitals that have not increased their requirements for interns during the ten-year period.

In hospitals approved for both intern and residency training, the number of internships offered for the same period will be limited to 70 per cent of the number offered in 1950 or to the total number offered in 1940, whichever is the larger.

For hospitals approved since the publication of the 1950 Internship and Residency Number, a similar quota based on comparable bed capacities and annual admission rates will be allocated. In hospitals with a rotating type of internship, the number of appointments will not be less than four.

Will Ross Dies

Will Ross, of Milwaukee, long an active supporter of health programs, died recently, leaving one-fourth of his estate to medical and cultural groups. Five per cent of this sum has been willed to the Library of the American Hospital Association and 20 per cent to the American College of Hospital Administrators.

Mr. Ross became interested in hospitals and sanatoriums during his fight against tuberculosis, which he developed while still in his teens. Much of his time after that was spent in health work. In 1944 he was elected president of the National Tuberculosis Association. He was the second layman to hold the office. In 1943 he was awarded the Hoyt E. Dearholt medal of the Mississippi Valley Conference for his contributions, particularly for his 30 years of work with the Wisconsin Anti-Tuberculosis League.

Also sharing in the bequest are the Wisconsin division of the American Cancer Society, National Tuberculosis Association, the Wisconsin Anti-Tuberculosis Association and the Curative Workshop.

"Doctor of Sick Hospitals"

Mother Mary Alice, superintendent of St. Clare's Hospital, New York City, and founder of that institution 17 years ago, received civic honors and the papal honor, the Bene Merenti gold medal, on her golden anniversary in June as a nun in the Third Order of St. Francis.

At the same time, the hospital's sixth building, the Regina Coeli Hall, was dedicated by Francis Cardinal Spellman. New York's Mayor Vincent Impellitteri and state controller J. Raymond McGovern, representing Gov. Thomas E. Dewey, were present at the ceremony.

Mother Mary Alice, called "the doctor of sick hospitals," has renovated old hospitals, built new ones, increased bed capacities and installed modern equipment, and has founded nurses training centers as well as founding and expanding clinics. Since she founded St. Clare's, she has increased the hospital's capacity from 45 to 440 beds.

Negroes on Medical Staff

Davis Hospital in Pine Bluff, Ark., has elected for the first time two Negro physicians to the medical staff of the hospital. The doctors, C. A. Lawlah and C. A. Flowers, are well known in the area.

Dr. Lawlah is a graduate of Rush Medical College, Chicago. He interned at Provident Hospital, Baltimore, and served his residency

MEET US IN ST. LOUIS

If you plan to attend
The American Hospital Association Convention
in St. Louis, Missouri, September 17-21,
we hope you will take time to visit

our exhibit in Booth 809.

We know that you will have a business-packed schedule
at the convention. But we also know
that your time will be spent profitably
in learning what hospitals throughout the country
are doing in expanding their facilities
to meet the steadily rising demands
being made upon them.

You will be particularly interested
in receiving a copy of our new "Fact File"
which contains valuable data on hospital fund
raising and the successful methods of preparing
the community for a fund appeal in advance of
the actual campaign.

B. H. Lawson Associates
Incorporated
ROCKVILLE CENTRE, NEW YORK

at Flint Goodrich Hospital in New Orleans. Dr. Flowers was graduated from Meharry Medical College in Nashville, served his internship at George W. Hubbard Hospital, Nashville, and his residency at McRae Memorial Tuberculosis Sanatorium in Alexander, Ark.

Building Research Congress

Marshall Shaffer, A.I.A., chief of the technical services branch of the Division of Hospital Facilities, Public Health Service, will represent the United States at the International Building Research Congress in London, September 11-20. This congress is sponsored by the International Union of Architects.

Mr. Shaffer, a widely known authority on hospital architecture, recently was promoted to engineer director in the Public Health Service.

Winner of the Edward C. Kemper Award for outstanding contributions to the architectural profession, presented by the American Institute of Architects in May, Mr. Shaffer has been active in American Hospital Association hospital planning activities. His branch in the Public Health Service reviews all architectural details of hospitals applying for federal aid under the Hill-Burton Hospital Survey and Construction Act and works continuously on the improvement of hospital design.

Cerebral Palsy Grant

A grant of $10,000 to continue a nationwide educational program for specialists in the field of cerebral palsy has been made by Alpha Chi Omega, women's fraternity, to the National Society for Crippled Children and Adults, Chicago.

The grant will make possible advanced study in the care and treatment of cerebral palsied children by specially selected physicians, therapists and educators during the next two years.

Cancer Mortality Decline

Indications of a decline in cancer mortality have been reported by the Metropolitan Life Insurance Company.

The company reports that where the primary site of the disease is accessible to diagnosis, the decline in the death rate from 1946-47 to 1949-50 was 2.4 per cent for men and 7.2 per cent for women. In inaccessible cases, the death rate among women declined 1.1 per cent, but increased among men by 4 per cent.

Increases in death rates were recorded for cancer of the lung and other respiratory areas.

The company also reported the general death rate in 19 countries has declined more than 8 per cent since before World War II. In nine of the countries the death rate declined by 20 per cent or more.

Tuberculosis Death Rate

Following a study covering 30 countries and extending from 1937 to 1949, the World Health Organization reported from Geneva that there has been a general decrease in deaths from tuberculosis since 1945, with a spectacular postwar fall in mortality rates in a number of European countries engaged in hostilities in World War II.

France, which in 1941 and 1942 showed rates as high as 134 and 128 for each 100,000 inhabitants, dropped to 68 for each 100,000 by 1949.

Italy's rate declined to 49 deaths for each 100,000 inhabitants from

TWICE AS MANY RECORDS IN THE SAME AREA

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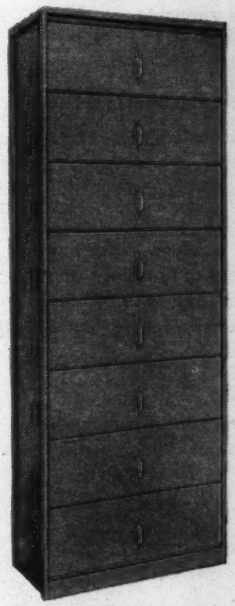

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The Visi-Shelf Filing System was developed as an answer to over-crowded and over-worked hospital Record Departments! Consisting of all-steel filing cabinets designed especially for increased record capacity, the Visi-Shelf system —

Actually *doubles* amount of record filing space as compared with 4 drawer vertical filing cabinets!

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a high recorded in 1942 of 102 deaths per 100,000. Norway showed a drop from 74 in 1944 to 52 in 1948. Denmark is the only country among those covered by the report that attained a mortality rate as low as 19 by 1949.

Two neutral countries of World War II, Portugal and Spain, maintain, together with Finland, the highest death rates from the disease among European countries included in the report. In 1948, the rates for Portugal and Spain were 148 and 114, respectively, and for Finland, 156.

Results of Plan Survey

Summarized results of the first comprehensive survey conducted of independent hospital and medical care plans throughout the country were published recently by Social Security Administration. Data are given on 251 prepayment plans unaffiliated with Blue Cross or Blue Shield and which range in size from Health Insurance Plan of Greater New York down to little groups with less than 50 members.

The 251 plans surveyed had a 1949 income of $93,800,000 and their expenditures totaled $82,500,000. Their combined beneficiary potential was 4,500,000 individuals, of whom 3,900,000 carried hospitalization insurance in the 216 plans offering this benefit. Slightly under 3,000,000 were covered with both hospitalization and medical care insurance, the latter either limited or comprehensive. Approximately 970,000 carried hospitalization insurance alone.

Thirty-four of the plans studied limit coverage to hospitalization, their size ranging from little community-wide cooperatives in the South to a few having average enrollments in excess of 200,000.

The report, prepared by Agnes W. Brewster, of the Social Security Administration Division of Research and Statistics, was published in the monthly *Social Security Bulletin* for May.

Children's Tumor Clinic

Children's Hospital, Pittsburgh, recently opened a tumor clinic for diagnosing cancer or tumors in children. Clinic facilities are available to outpatients and inpatients of the hospital who are examined every Tuesday. A tumor board composed of physicians experienced in diagnosing such conditions reviews all cases referred to it.

The new clinic is related to similar ones at Presbyterian and Elizabeth Steel Magee hospitals in Pittsburgh.

Dr. Gordon Heads College

Dr. Burgess Lee Gordon, clinical professor of medicine at Jefferson Medical College and director of Jefferson Hospital's department for diseases of the chest, has been appointed president of Woman's Medical College of Pennsylvania, Philadelphia.

Dr. Gordon is a well-known medical educator and an authority on diseases of the chest.

Free Clinic Program

A free clinic program for early detection of cardiac disorders is being planned by the Missionary Sisters of the Sacred Heart, administrators of Columbus Hospital, New York City, in commemoration of Mother Cabrini's intense devotion to the Sacred Heart of Jesus and in celebration of the dedication of

BASIC PATIENTS' MEDICAL RECORD

Consisting of New Improved Forms:

- Patient's Index Card
- *Summary Sheet
- *Record of Admission
- History Sheet
- Physical Examination
- Laboratory Report
- Progress Notes
- Physician's Orders 1 and 2 sides
- Graphic Chart 8-day, 4-hour, 4-8-12
- Nurses Bedside Record 1 and 2 sides
- Report of Consultation
- Report of Operation
- Report of Pathologist
- X-ray Report
- Patient's Clothes List in duplicate (50 dup. sets to a book)
- Report of Accident in duplicate (50 dup. sets to a book)

*"Summary Sheet" and "Record of Admission," forms can be used as "One-typing Sets."

THESE NEW FORMS . . .

as a result of careful research and analysis, offer many improvements. Identical arrangement of headings on all forms assures uniformity and aids in finding information quickly. Color scheme helps to easily locate various forms in the patients medical record.

MEET AUTHORITATIVE REQUIREMENTS

These new forms conform to hospital standardization requirements and meet the hospital point rating specifications.

COST LESS

Large volume production, reasonably priced, enables you to purchase these forms at a lower cost, saving the hospital many dollars.

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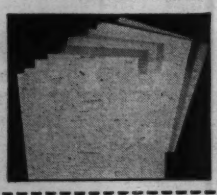
PHYSICIANS' RECORD CO.

161 West Harrison Street, Chicago 5, Illinois

A FREE SET FOR EXAMINATION



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3 IMPORTANT
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"CHF" No. 411 base with No. 896 seat. Simple design and colorful stripes have made this a leading stool today.

1 MODERN DESIGN *Plus* ATTRACTIVE COLOR COMBINATIONS!

Your choice of many color combinations and three upholstering fabrics enable you to select stools and tables that harmonize well . . . and add colorful beauty to your installation!

2 LIFETIME FINISH — SMOOTH, EASY TO KEEP CLEAN!

"CHF" Porcelain Enamel is a heat treated finish. It is fused on solid cast iron which insures perfect enameling and strength that stands up under heavy use. Surface has a glass-like smoothness that's easy to maintain . . . keeps upkeep to a minimum!

3 DURABILITY OF CAST IRON "ONE-PIECE" CONSTRUCTION!

Columns and bases of these "CHF" stools are *cast solid in one piece* — not assembled stampings or spinnings! You have an unbroken line from seat to floor and the durability of cast construction assures you of stools and tables that *last a lifetime!*

No. 919-254 Mushroom table base with Sanite (non-vitreous) enamel columns to match or contrast with porcelain enamel base.
Write for Illustrated Catalog showing other finishes and designs in the complete "CHF" line.
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FOR 1001 SURGICAL USES

Vaseline
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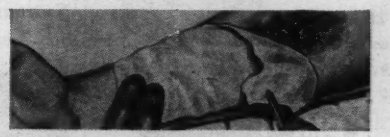
Sterile Petrolatum Gauze

as dressing, drain, or pack

ready for immediate application — always sterile, always ready . . . emollient . . . non-adherent . . . non-irritating . . . non-macerating . . . for OR—WARDS — OPD — EMERGENCY — CS — CASUALTY UNITS.

2 sizes: each 6 envelopes to the carton. Unit envelope . . . one 3" x 36" dressing. Duplex envelope . . . two 3" x 18" dressings.



as dressing for burns • abrasions athletic injuries • circumcisions • carbuncles • leg ulcers • plastic surgery • *many other traumatic or surgical wounds.*

as pack in abdominal incisions hemorrhoidectomy • compound fractures osteomyelitis • arthrotomy, etc.

Chesebrough Mfg. Co., Cons'd

Professional Products Division

NEW YORK 4, N. Y.

VASELINE is the registered trade-mark of the Chesebrough Mfg. Co., Cons'd

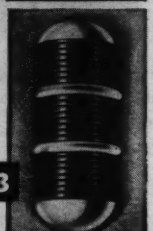
Specialty Lights *by* CANNON

(Above) DNP-1 light used in residence, with face plate removed, showing construction of (2 gang) plaster ring box cover.

DNP-2

Low Voltage or 115V

Plastic prism lens in red, green, blue, amber and crystal—inside surface sandblasted.

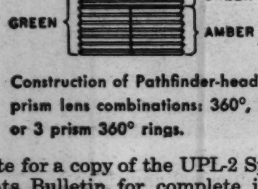


DNP-3

Face plate of Plaskon Stainless Steel or various Hammertone finishes.

DMP-1

Marine-type Pedestal light with "Pathfinder" head may be mounted on post, wall, ceiling, etc.



Construction of Pathfinder-head type prism lens combinations: 360°, 180°, or 3 prism 360° rings.

Write for a copy of the UPL-2 Specialty Lights Bulletin for complete information. Add PL-3 if interested in the Pathfinder type lights.

Address Cannon Electric, 3209 Humboldt Street, Los Angeles 31, Calif. Canadian offices and plant: Toronto, Ont. Export: Frazar & Hansen, San Francisco, Calif. Representatives in principal cities.

CANNON ELECTRIC

a new wing of the hospital by Francis Cardinal Spellman.

Mother Cabrini, now known as Saint Frances Xavier Cabrini, was the founder of Columbus Hospital and six other hospitals in the United States.

Columbus Hospital researchers are experimenting with new instruments that may be valuable in the earlier detection of heart conditions. The researchers are also beginning a program of evaluating new drugs for the control of heart disease.

Public Relations Director

John R. Kinsey, former newspaperman and associate editor of a mechanics magazine, has been appointed public relations director at Wesley Memorial Hospital, Chicago. He has been a member of the public relations staff at Northwestern University and director of public relations for an appliance firm.

Red Cross Officials Resign

Dr. G. Foard McGinnes, present national medical director and for five years vice president for health services, American National Red Cross, has resigned. He will be succeeded by Maj. Gen. David Grant, who recently was appointed director of the Red Cross national blood program.

The assistant national director of nursing services for the American National Red Cross, Frances Crouch, has resigned to become nurse consultant, Federal Civil Defense Administration.

Donations Equip Laboratory

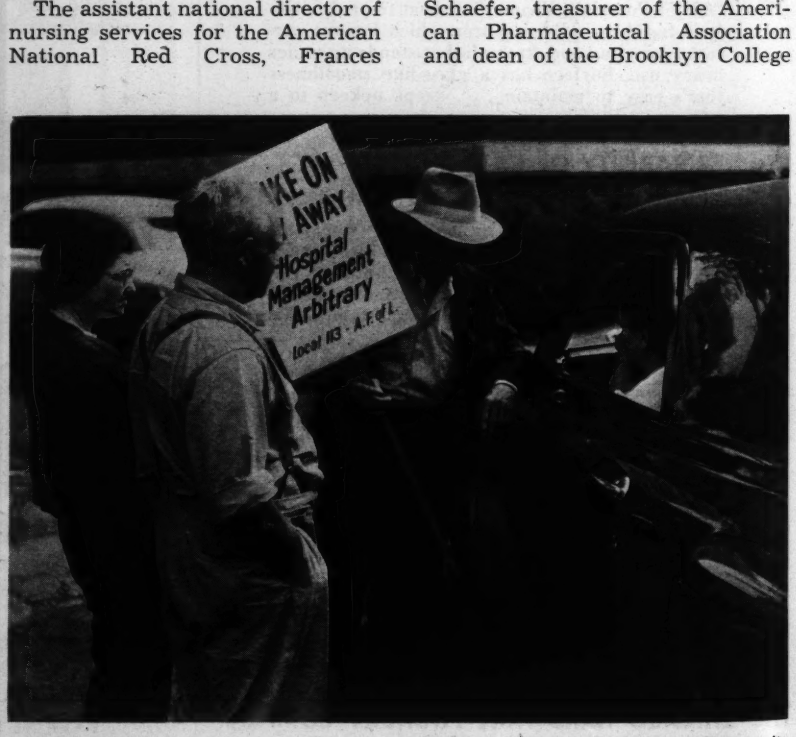
Leo Wallach, a Chicago hotel man who has worked anonymously to raise funds for research in ulcerative colitis, will see his work rewarded in a newly equipped laboratory at the University of Chicago Clinics. A plaque dedicated to Mr. Wallach has been placed on the door of the laboratory.

Mr. Wallach, who became interested in ulcerative colitis when his son became ill of it, noted the costliness of the disease and the need for new equipment for its study. Hospitalization alone, in typical cases, has cost from $800 to more than $5,000, exclusive of drugs, nursing care and professional fees.

Mr. Wallach made the first of his eight contributions in 1949 and since then has enlisted the support of friends to make the complete scientific laboratory possible. Contributions also will be used to purchase drugs for ulcerative colitis patients unable to afford the medication.

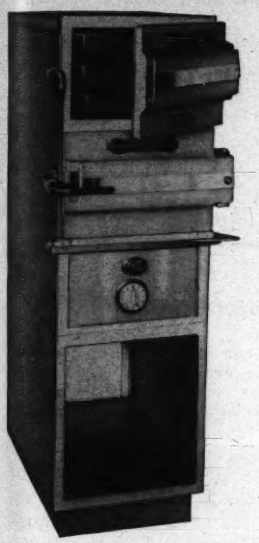
Outstanding Pharmacist

The Remington Medal, pharmacy's highest honor, will be presented this fall to Dr. Hugo H. Schaefer, treasurer of the American Pharmaceutical Association and dean of the Brooklyn College



PICKETS ARGUE with a nurse trying to enter Fairview Hospital during the Minneapolis hospital strike. Ten private hospitals were affected by the "spontaneous work stoppage."

Steamcraft

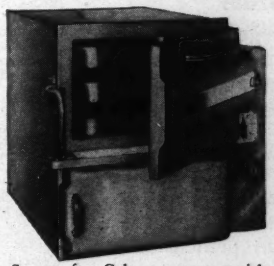


Steamcraft two-compartment model. Takes 6 full size pans or 12 half-pans. Base and indicating timer shown are additional.

Any Kitchen can Afford the Small Economy Steamer—Steamcraft

Steamcraft Junior steam cookers have so many advantages over other types of cooking equipment—it's no wonder hundreds of ***smaller*** operators are turning to these compact, hard-working ***economy*** models! They speed up your cooking schedule for many different foods, reduce shrinkage and food waste, save ***plenty*** on fuel cost. They cut down labor costs on handling and cleaning a lot of heavy pots and pans. Nothing burns, nothing scorches, in a steamer. A Steamcraft ***gets going*** quickly, and prepares perfectly cooked, appetizing, attractive food, full of good taste and valuable nutrients.

Besides, you can use your Steamcraft also for pre-heating, blanching, warming, and freshening various meats, baked goods, and vegetables. It cooks and ***conditions*** all these foods rapidly, efficiently, in quantities as ***needed***.



Steamcraft Cub counter model. Takes 3 full size pans or 6 half-pans. Can be furnished with base. Indicating timer shown, at slight extra cost.

Steamcraft 1 or 2 compartment steamers are supplied for table or counter use, or with bases. Steam-Chef heavy duty steamers come in 1-2-3-4 compartment sizes. Any of these steamers may be obtained for direct steam line connection, or for electricity, or any kind of gas operation. Ask your supply house or us for full details.

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Nurses Say:

"It's the easiest and fastest high-low bed to adjust"

HILL-ROM offers an entirely new idea in adjustable-height beds. Instead of the usual four posts, with all four posts serving as telescoping members, this new Hill-Rom bed has but two pedestals, with an improved telescoping action incorporating the use of a heavy coil spring in the innertube.

This spring compensates for the weight of the bedspring, the mattress, and part of the patient's weight, making it possible for the bed to be raised or lowered faster, with fewer turns and less effort on the part of the nurse.

This new Hill-Rom high-low bed is a combination of wood and metal. Structural parts are of steel, with baked-on enamel finish. The panels are laminated 5-ply Walnut or Rift Oak. Size, 3′ wide x 7′-6″ long. Either Hill-Rom's standard heavy duty Gatch spring, the No. 15 crankless Trendelenburg or the No. 25 two-crank Trendelenburg spring may be used.

Patients find it easy to get in and out of the Hill-Rom High-Low bed in the low position.

Complete particulars on this new Hill-Rom High-Low Bed will be sent on request.

HILL-ROM COMPANY, INC., BATESVILLE, INDIANA

HILL-ROM
Furniture for the Modern Hospital

FOR PROMPT
INTESTINAL CLEANSING

Evacuant ACTION
WITHOUT
REACTION

When hospital patients require thorough intestinal cleansing prior to diagnostic or surgical procedures . . . or experience transient costive distress . . . Phospho-Soda (Fleet) in larger doses is widely used to induce a prompt, complete evacuation, much like the response to an enema. Yet its gentle action is quite free from irritation, griping, or other adverse reactions. Samples on request.

Phospho-Soda (Fleet) is a solution containing in each 100 cc. sodium biphosphate 48 Gm. and sodium phosphate 18 Gm. Both Phospho-Soda and Fleet are registered trademarks of C. B. Fleet Co., Inc.

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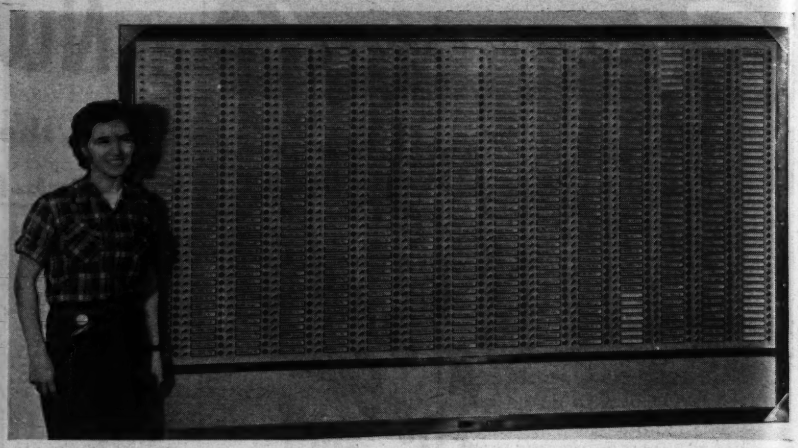
There is only one—

PHOSPHO-SODA (FLEET)
A Laxative for Judicious Therapy

ACCEPTED FOR ADVERTISING BY THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION



MARY RONEY stands beside the 600-name doctors' in-and-out register to be installed in the Jackson Memorial Hospital, now nearing completion in Jacksonville, Fla. The register, almost 9 feet long and 4½ feet high, is the largest to be constructed by its builder, a Los Angeles electric development company. Miss Roney installed the unit's wiring.

of Pharmacy, by the New York branch of the American Pharmaceutical Association.

The medal is awarded to the individual who has done most for American pharmacy during the previous year or whose contributions to the advancement of the profession have been outstanding.

Dr. Schaefer is an authority on pharmaceutical law and problems arising under state and federal food, drug and cosmetic legislation. He is the author of many papers and several textbooks and has been active in many pharmaceutical organizations and committees.

March of Dimes Grant

The National Organization for Public Health Nursing has received a March of Dimes grant of $33,450 to continue its joint orthopedic nursing advisory service to nurses, nursing schools and public health nursing agencies.

The purpose of the program is to improve the techniques of patient care, particularly in principles of body mechanics and posture.

Civil Defense Drill

The first civil defense control drill to be held in a state institution in Queens, N. Y., took place in June at the Creedmore State Hospital. The exercise was planned to test preparations to protect persons in institutions in the event of an enemy attack.

New Name for Hospital

The Corporation of New England Hospital for Women and Children, Roxbury, Mass., has announced that permission has been granted by the Commonwealth of Massachusetts to change the name to New England Hospital. The hospital has 193 beds and 75 bassinets.

CURRENT LISTING OF NEW ASSOCIATION MEMBERS

NEW INSTITUTIONAL MEMBERS

CALIFORNIA

Agnew—Agnews State Hospital
Auburn—DeWitt State Hospital
Camarillo—Camarillo State Hospital
Eldridge—Sonoma State Home
Imola—Napa State Hospital
Merced—Mater Misericordiae Hospital
Modesto—Modesto State Hospital
Norwalk—Norwalk State Hospital
Patton—Patton State Hospital
Sacramento—Department of Mental Hygiene, State of California
San Francisco—The Langley Porter Clinic
Spadra—Pacific Colony
Stockton—Stockton State Hospital
Talmadge—Mendocino State Hospital

FLORIDA

DeLand—The Fish Memorial Hospital
Lantana—Southeast Florida Tuberculosis Hospital

IDAHO

St. Maries—St. Maries Hospital
Twin Falls—Twin Falls Clinic Hospital

ILLINOIS

Peoria—Mahoney Convalescent Home

IOWA

Hartley—Hand Hospital

KANSAS

Wichita—Sedgwick County Hospital and Clinic

NEW MEXICO

Las Cruces—Memorial General Hospital

NEW YORK

Lockport—Lockport City Hospital

SOUTH DAKOTA

Aberdeen—Bureau of Indian Affairs, Aberdeen Area Office

TEXAS

Austin—Holy Cross Hospital
Canyon—Neblett Hospital
Dallas—Elm Rest Hospital

UTAH

Dragerton—Dragerton Hospital

YARDSTICK OF QUALITY

...more than 20 years long!

The name *Deknatel* has been recognized as the Yardstick of Quality in surgical silk for more than 20 years. The reason for this lies in the unusual tensile strength of the suture material — the constant uniformity of diameter — and its extreme pliability. Deknatel Surgical Silk is moisture and serum resistant — non-absorbable, non-capillary, and non-slipping. The unvarying quality and uniformity of Deknatel Sutures have won the confidence of surgeons everywhere. J. A. Deknatel & Son, Queens Village 8, L.I., N.Y.

Sold by Surgical-Hospital Supply Houses.

DEKNATEL SURGICAL SUTURES

The First and Still The First

OTHER DEKNATEL PRODUCTS—DEKNATEL SURGICAL NYLON, MINIMAL-TRAUMA NEEDLES WITH ATTACHED SUTURES, NAME-ON BEADS

Nursing Help Available—
24 HOURS A DAY!

The DEBS Medi-Kar is like another nurse on your staff. Saves your nurses time and work—permits more nursing time for other duties.

APPLICATION FOR EMPLOYMENT

NAME: DEBS Medi-Kar

POSITION: Time-saver for your nursing staff

EXPERIENCE: Serving with satisfaction in over 300 leading hospitals.

QUALIFICATIONS: Distributes up to 36 medications on one trip; cuts medication time in 1/2. Positive medication identification system. Sturdy—made of gleaming stainless steel. Noiseless, 4-inch swivel rubber wheel casters.

*Patent Applied for Trade Mark Reg.

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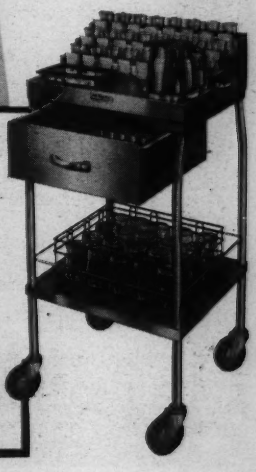

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- 24 medicine glasses
- 12 loaded, sterile hypo syringes, 2cc or 5cc
- Stainless steel water pitcher
- Stainless steel covered tray for used syringes
- Neoprene covered rack to hold 24 water glasses

...a place for everything and everything in its place for one nurse to distribute on a single trip from the nursing station.

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118 S. Clinton St., Chicago 6, Ill. P-28
Gentlemen: Please send me free booklet on the MEDI-KAR* and how it will save nurses' time and work in my hospital.

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Hospital.....

City.....Zone...State.....